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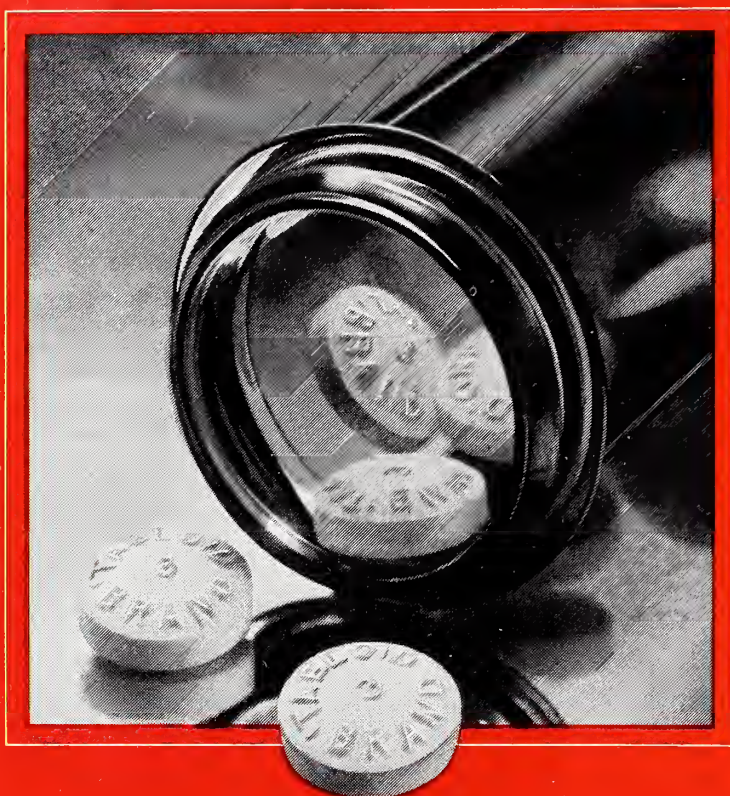
Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

VOLUME 154, NO. 1, JULY, 1978

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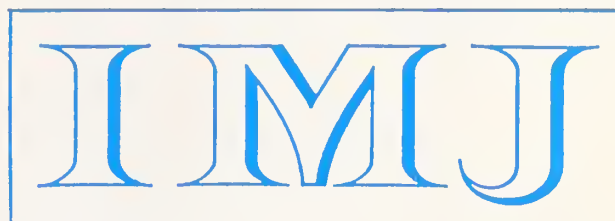


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Illinois Medical Journal

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malforma-

tions as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Abstracts of Board Actions

June 3, 1978

Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request at the headquarters office of ISMS.

Medicare Peer Review

ISMS has contracted with Electronic Data Systems (EDS) to provide peer review and professional relations services if HEW awards EDS a contract to administer Medicare Part B in Illinois. Under HEW's plan, one carrier will be selected to administer the program throughout the state. The carrier selected will begin operations April 1, 1979, in Cook County and July 1, 1979, in the remainder of the state. The peer review reimbursement rate would be \$38, with county societies receiving \$35 per review and ISMS retaining \$3 to cover administrative costs. This is similar to the ISMS contract with Wisconsin Physicians' Service to perform peer review, facilities review and professional relations on behalf of the CHAMPUS program in Illinois.

Medicaid

ISMS will assist the Illinois Department of Public Aid in securing the services of six physicians to review the practices of some 49 physicians suspected of prescription abuse of drugs such as Talwin and PBZ. However, ISMS will urge the reviewing physicians—who will be deputized as IDPA agents—to withdraw from the reviews if: (1) IDPA demands fiscal records; or (2) The physician being investigated refuses to produce medical records because he does not have the patient's consent. IDPA will be responsible for securing patient authorization in such cases. Findings of the reviews will be presented to the State Medical Advisory Committee.

The Society will present objections to a proposed IDPA rule which would limit reimbursement of physicians earning \$25,000 or more per quarter from Medicaid to 80% of the statewide pricing screens. The level of statewide pricing screens is dependent upon the action which the General Assembly takes regarding the governor's proposed \$20 million increase in physician reimbursement.

ISMS will provide legal assistance if court action results from an upcoming IDPA audit of a Chicago physician's Medicaid billings. ISMS assistance will be limited to an effort to protect the physician-patient relationship and confidentiality of medical records. Because the court decision could impact on all Illinois physicians, ISMS involvement falls within guidelines governing legal assistance adopted by the Board last August.

Statewide PSRO Council

The Executive Committee was authorized to designate two ISMS representatives to the Statewide PSRO Council. Prior to submitting the nominations the Society will consult with the governor to discuss his appointments to the Council. HEW has requested the broadest possible physician representation (specialties and practice settings). Membership on the Council will consist of 2 physicians designated by ISMS; 2 physicians designated by Illinois Hospital Association; 1 physician representative from each PSRO in Illinois and 4 public representatives, at least two of whom will be appointed by the governor. The PSRO Council will coordinate PSRO activities, disseminate relevant data concerning the program, and assist in evaluating PSRO performance and assuring compliance.

(Continued on page 47)

Time is the test of all things.



BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

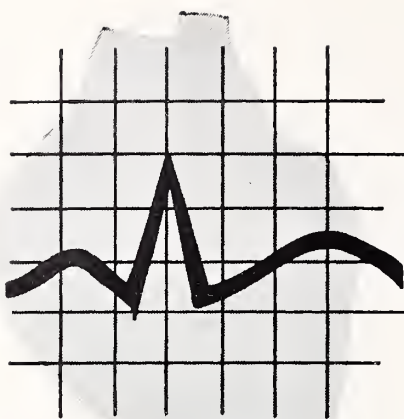
In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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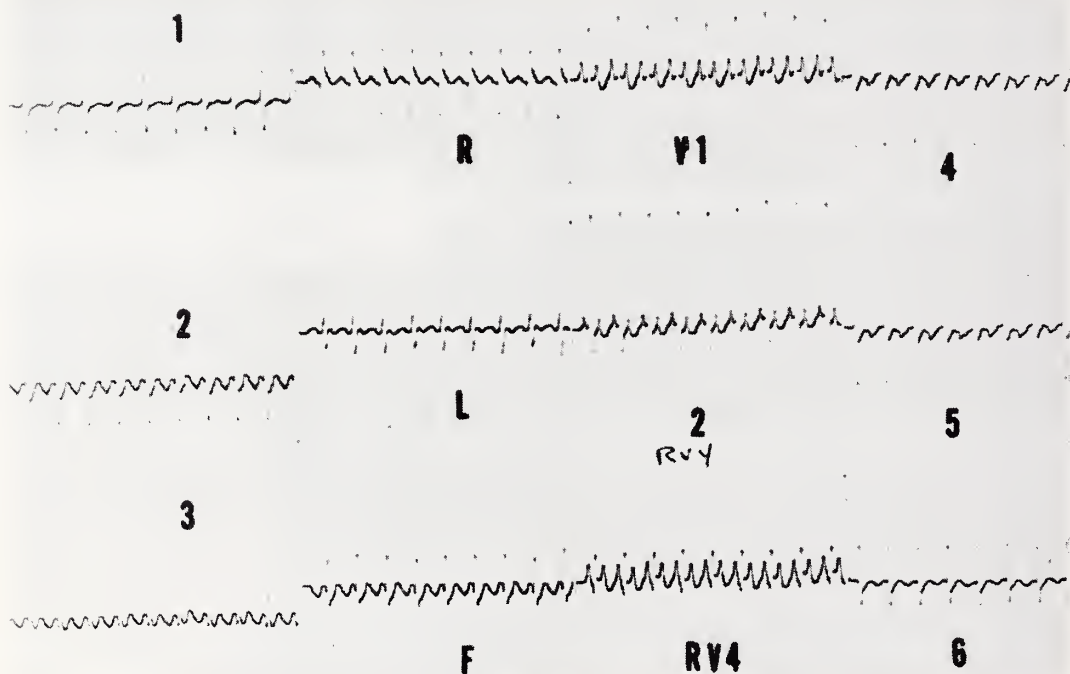
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JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This patient is a five-week-old infant who presents with symptoms of congestive heart failure. He was the product of a normal labor and delivery although a tachycardia of 200 beats per minute was once recorded. Now his mother noted breathlessness and difficulty in feeding. Physical examination showed hepatomegaly, a tachycardia of 215 beats per minute, and a grade 3/6 systolic cardiac murmur at the base of the heart. This ECG was taken.



Questions:

1. The ECG shows:

- Atrial flutter with 2:1 atrioventricular block, an atrial rate of 430 beats per minute.
- Atrial tachycardia with 2:1 atrioventricular block.
- Right ventricular hypertrophy.
- Left ventricular hypertrophy.

E. Findings compatible with a ventricular septal defect.

2. Management of this young patient could include:

- Digitalis.
- Quinidine.
- DC cardioversion.
- Cardiac catheterization.
- All of the above.

(Continued on page 46)

Blue Cross®
Blue Shield®



REPORT

FOR *Illinois Physicians*

Health Care Achievement Awards

Dear Doctor:

Critics contend that the private health care sector talks about its problems, but rarely does anything positive about them.

The media, government, consumer groups and others demand results. Congressman Dan Rostenkowski (D., Ill.) who, by virtue of being Chairman of the Health Subcommittee of the Committee on Ways and Means, can help change the course of our health care system, put it this way: "The health care industry must recognize that if it proves unwilling or unable to immediately address the problem of rising costs, it cannot reasonably object to government initiatives."

The 1978 Blue Cross and Blue Shield Symposium on November 15 is designed to demonstrate that the private health care sector not only can, but is tackling its problems. This will be achieved by recognizing initiatives that have been made by the private sector in dealing with areas of health costs, quality and/or accessibility. This recognition will bring a great deal of public attention to the initiatives that are being carried out by the private sector—placing the private sector in a far more favorable light than it is currently perceived!

You are invited to tell us about your actions that are designed to have a positive impact on the cost, quality and/or accessibility of health care services.

The entries will be judged by a five-member panel comprised of representatives from the Illinois Hospital Association, Illinois State Medical Society, Chicago Hospital Council, Chicago Medical Society and the Illinois Clinic Managers Association.

Entries will be divided into three groups with awards being given in each category. The groups include hospitals, physicians and employers.

Full details of the competition and how to complete an entry appear on this page in the adjoining column.

We hope that you will submit an entry because we believe that our Symposium III will do much to rebuild confidence in the private health care sector.

Sincerely,
Richard F. O'Connell
Vice President
Public Affairs
Blue Cross and Blue Shield

The purpose of the Health Care Achievement Awards is to demonstrate that the private sector is making significant progress in dealing with the issues of health care costs, quality and/or accessibility as well as to give deserved recognition to those individuals, institutions and employers responsible for outstanding achievements in these areas.

Health Care Achievement Awards will be presented in three categories: hospitals, physicians and employers. For physicians, the three categories are solo practitioners, group practices and prepaid groups practices (including foundations for medical care). Clinic managers, along with medical directors, may be cited in the case of group practices and prepaid groups.

Entries will be judged on the impact a described program or effort has made on the cost, quality and/or accessibility of health care services. An award, for example, might be given for a program that promotes a less costly type of health care without sacrificing quality such as an out-patient surgical program. An award could be given for the establishment of a medical clinic in a rural area that would improve the accessibility of health care services for area residents. A third example would be an award for an employee physical fitness program.

The panel of judges will contact you if additional information is required after an entry is submitted. For further details on the Health Care Achievement Awards, please contact Doreen Molloy at (312) 661-4279.

Entries should be mailed to Health Care Achievement Awards, 14th Floor, Blue Cross and Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601.

Entries must be received by September 15, 1978.

Name of Physician Important On Medicare Claim

In order to process a Medicare claim, it is essential that the physician who rendered the service is identified by his first and last name. The name of the group, or a listing of the physicians in the group, is *not sufficient information* for identification since each physician is assigned his own Medicare provider number.

When the multiple listing billing form is used, the name of the *specific physician who rendered the service* should be underlined in ink or bold pencil, circled or otherwise precisely identified on the bill.

The best method of identification is to affix the physician's imprinted Medicare label on the bill, available from the Medicare carrier. Identification of the physician is especially important following the passage of the Sunshine Act by the government, since it permits the public disclosure of Medicare payments to physicians.

Failure to provide proper physician identification results in the delay of the claim and perhaps payments listed erroneously as having been made to a particular physician.

Gallium-67 Citrate Scan

This diagnostic procedure involves the use of Gallium-67 Citrate in demonstrating the presence and extent of such malignancies as lymphomas, Hodgkins disease and bronchogenic carcinoma.

Program payment may be made for medical imaging procedures when performed with Gallium-67 Citrate, if the scan is performed with Gallium-67 Citrate produced by a manufacturer that has FDA approval for this radiopharmaceutical, and, if the scan is also reasonable and necessary for the individual patient. To date, the FDA has only approved this radiopharmaceutical as manufactured by the New England Nuclear Corporation (effective May 17, 1976) and Diagnostic Isotopes, Inc., (effective December 16, 1977). If the FDA approves Gallium-67 Citrate produced by other manufacturers, payment may also be made for scans performed on or after the effective date of approval, which utilize Gallium-67 Citrate produced by such manufacturers.

Changes in Participation and Certification of Laboratory Procedures

Notices were received from the Medicare Bureau of the following changes in participation and certification of procedures of laboratories in the Medicare program:

Approved for Participation:

Dav-Kim Portable X-Ray, 409 Barnsley Place, Northbrook, Illinois 60062 (Provider Number 14-9817) has been approved as a supplier of portable X-ray services under the Medicare program. The effective date of coverage is January 23, 1978.

Liberty Portable X-Ray, 5339 South Major, Chicago 60638 (Provider Number 14-9816) has been approved as a supplier of portable X-ray services under the Medicare program. The effective date of coverage is July 25, 1977.

Notification of Closing:

Peterson Clinical Laboratory, 2424 West Peterson, Chicago 60645 (Provider Number 14-8159) closed, effective April 30, 1978. No payment can be made under the health insurance program for services rendered on or after the effective closing date.

Changes in Approved Procedures:

Bowers Laboratory, 7318 Madison Street, Forest Park is no longer approved to perform Procedure 330-Chemistry-Other, effective May 1, 1978. The laboratory is still approved to perform procedures in Bacteriology, Parasitology, Serology, Routine Chemistry, Clinical Microscopy, Blood Group and Rh. Rh Titers, Hematology, and EKG Services.

F & M Medical Laboratory, Inc., 4554 North Broadway, Chicago is no longer approved to perform Procedure 130-Parasitology, 330-Chemistry-Other, and 710-EKG Services. These deletions are effective May 1, 1978. The laboratory is still approved to perform procedures in Bacteriology, Serology, Chemistry-Routine, Clinical Microscopy, Hematology, and Blood Group & Rh.

Royal Medical Laboratory, 3940 West Division Street, Chicago is no longer approved to perform Procedures 120-Mycology; 130-Parasitology; and 510 Rh Typing. The deletions were effective April 13, 1978. The laboratory is still approved to perform procedures in Serology, Chemistry-Routine; Clinical Microscopy, Hematology and Diagnostic Cytology.

Clearing Industrial Clinic, 5548 West 55th Street, Chicago is no longer approved to perform Procedure 330-Chemistry-Other, effective April 13, 1978. The laboratory is approved to perform procedures in Serology, Routine Chemistry, Clinical Microscopy and Hematology.

Franklin Park Medical Laboratory, Inc., 9711 West Grand, Franklin Park, Illinois 60131 is no longer approved to perform Procedure 330-Chemistry-Other. The laboratory is approved to perform Procedures 400-Hematology and 710-EKG services.

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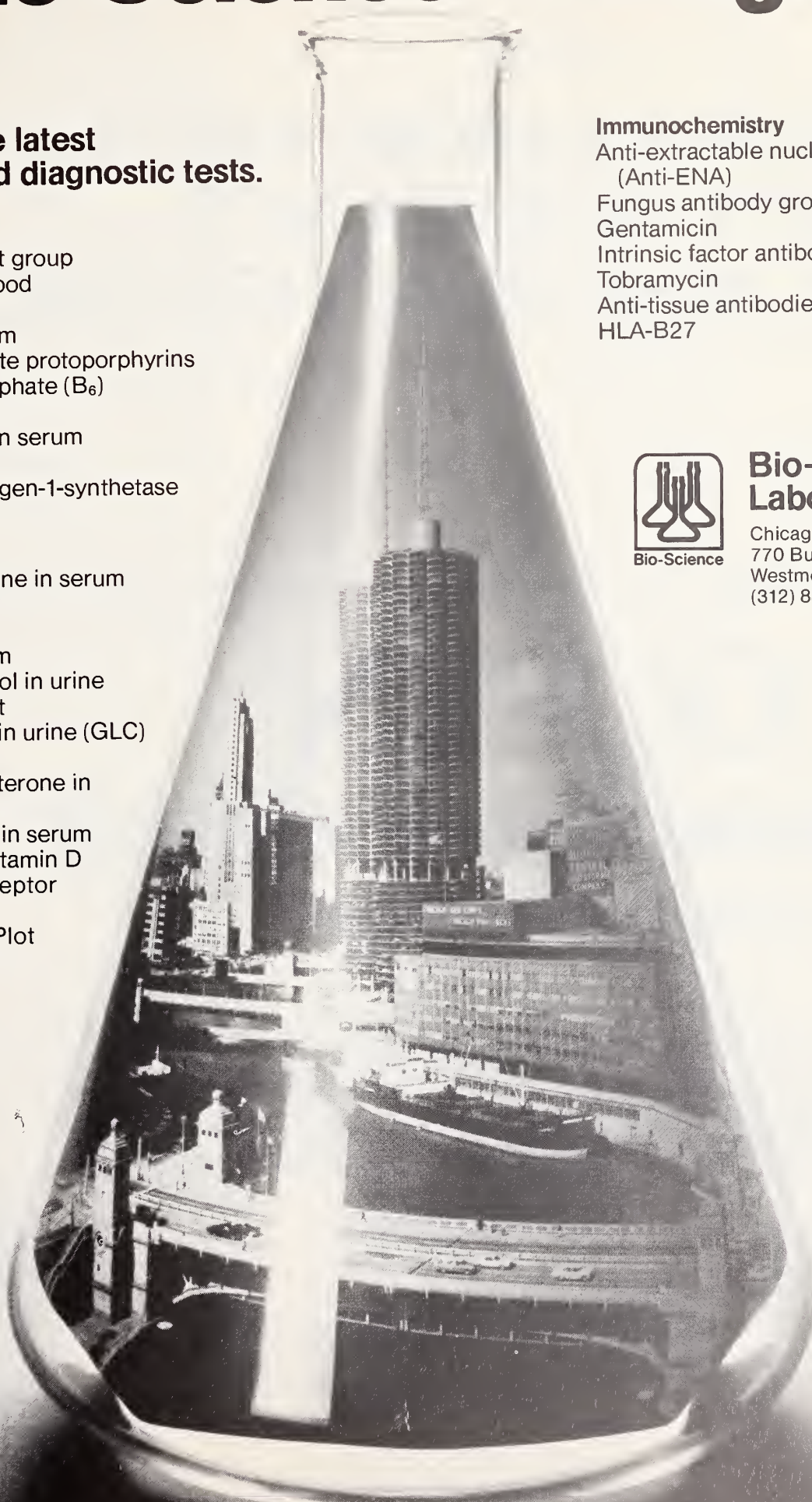
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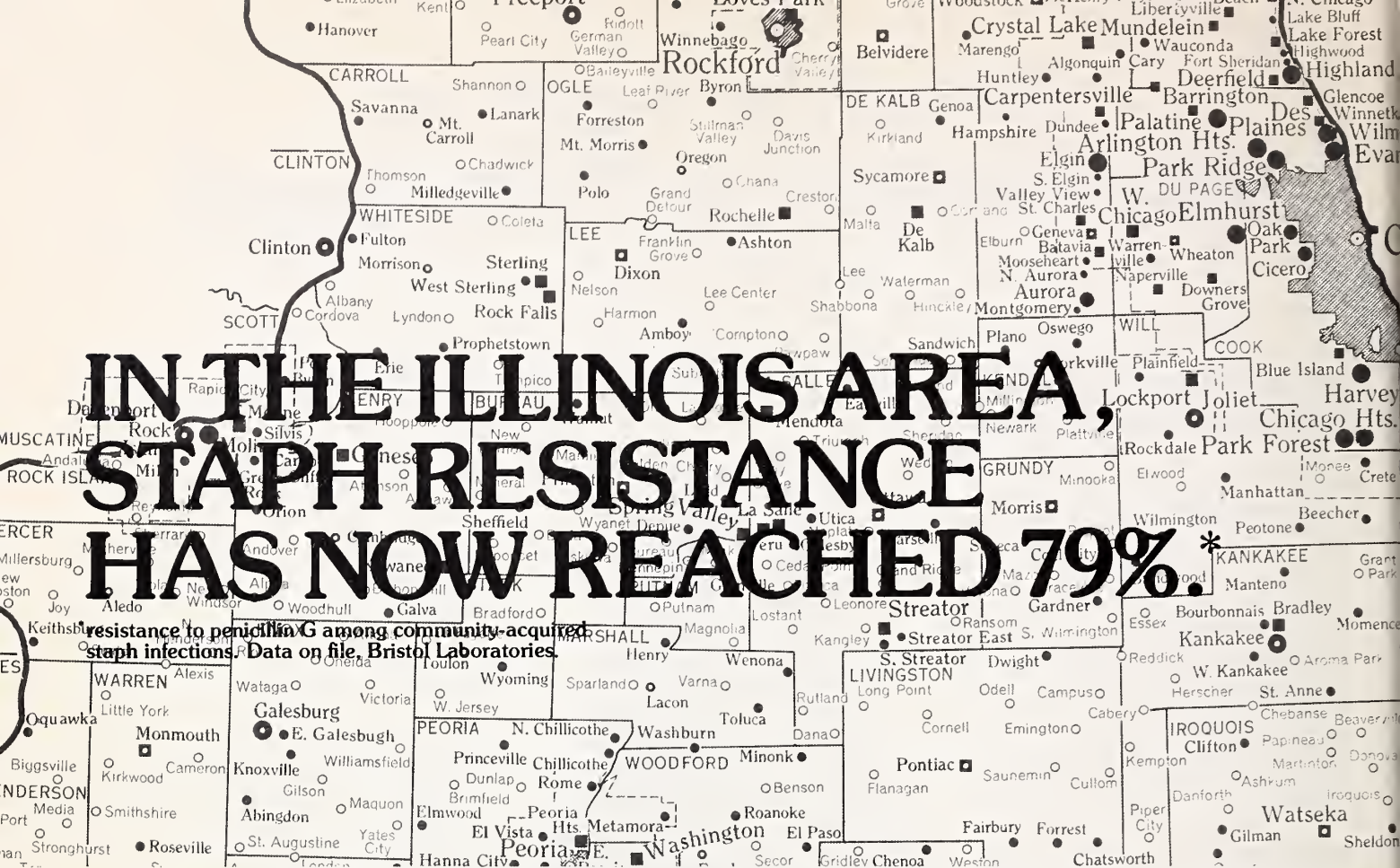
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†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.
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‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



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Brief Summary of Prescribing Information
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 For complete information, consult Official Package Circular.
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Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

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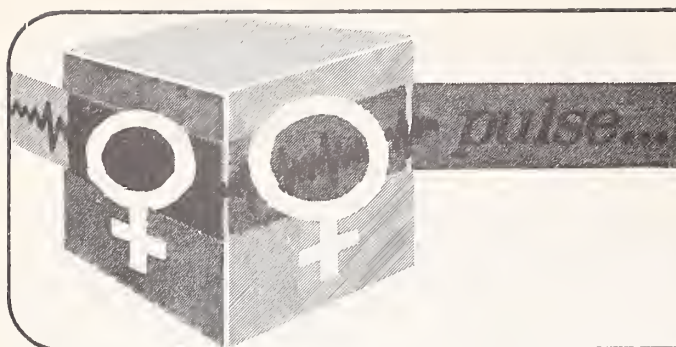
for July, 1978

Clinics for Crippled Children Listed for August

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will count nineteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical social and nursing services. There will be nine special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- August 1 Park Ridge Cardiac—Lutheran General Hospital
- August 2 Hinsdale—Hinsdale Sanitarium
- August 3 Sterling—Community General Hospital
- August 3 Lake County Cardiac—Victory Memorial Hospital
- August 4 Division Cardiac—U. of I. at the Medical Center
- August 8 Peoria—St. Francis Hospital
- August 8 East St. Louis—Christian Welfare Hospital
- August 9 Rockford—St. Anthony's Hospital
- August 9 Champaign—McKinley Hospital
- August 9 Joliet—St. Joseph's Hospital
- August 10 Springfield—St. John's Hospital
- August 10 Kankakee General—St. Mary's Hospital
- August 11 Chicago Heights Cardiac—St. James Hospital
- August 14 Peoria Cardiac—St. Francis Hospital
- August 15 Rock Island—Moline Public Hospital
- August 15 Belleville—St. Elizabeth's Hospital
- August 16 Springfield Ped-Neuro—St. John's Hospital
- August 16 Chicago Heights General—St. James Hospital
- August 17 Rockford—Rockford Memorial Hospital
- August 17 Bloomington—Mennonite Hospital
- August 17 Elmhurst Cardiac—Memorial Hospital of DuPage County
- August 18 Kankakee Cardiac—St. Mary's Hospital
- August 21 Maywood—Loyola Medical Center
- August 22 Peoria—St. Francis Hospital
- August 23 Aurora MM—St. Joseph Mercy Hospital
- August 24 Litchfield—St. Francis Hospital
- August 25 Evanston—St. Francis Hospital
- August 25 Chicago Heights Cardiac—St. James Hospital
- August 28 Peoria Cardiac—St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



of the ISMS auxiliary

MRS. EUGENE VICKERY, Editor

Growth Patterns

New Officers Introduced



MRS. EARL V. KLAREN, PRESIDENT, ISMSA

The Illinois State Medical Society Auxiliary elected three new vice presidents at the April meeting: Mrs. Harlan Failor, Mrs. Don Hinderliter and Mrs. Harold Keegan.

Pat Failor, First Vice President (Membership) will be responsible for encouraging new memberships. Pat has been a member of the ISMSA Board of Directors for seven years. She has served as Public Affairs Chairman, a Director, (responsible for members-at-large) Treasurer, Third Vice President (Communications) and president of the Champaign County Medical Auxiliary.

As Second Vice President (Programs), Mrs. Don Hinderliter is available to county medical society auxiliaries with pertinent information and will serve as our liaison with the AMA Auxiliary Project Bank. Diane holds degrees from Northern Illinois University and the Rockford Memorial School of Nursing. She served as president of the Ogle County Medical Auxiliary, 1975-78, and ISMSA State Health Education and Health Manpower Chairman in 1976-77. Diane's husband Doctor Don Hinderliter, a family practitioner, is currently ISMS Public Affairs Committee Chairman.



Pictured above, top row, l-r, First Vice President Pat Failor and Director Jean Hodges. Bottom row, Diane Hinderliter, Second Vice President and Third Vice President Bonnie Keegan.

Mrs. Harold Keegan, Third Vice President (Communications) will assist constituent auxiliaries in communications efforts and publications. Bonnie, who edited *PULSE* for three years and is the immediate past Community Health Chairman, is well-versed in public relations. Bonnie and her husband, Doctor Harold Keegan, a neurosurgeon, live in Kankakee with their four children. She is the former president of the Kankakee County Auxiliary, as well as chairman of community health and special projects.

Our new vice presidents are anxious to help county efforts. Please call upon them to help you make the most of auxiliary involvement. Better yet, take advantage of the opportunity to meet them at Fall Conference in September.



Medical Records and Patient Care To Highlight Annual Symposium

BY MAGDA BROWN, CHAIRMAN, PUBLIC RELATIONS

The American Association of Medical Assistants, Illinois Society, will hold an all-day educational program on Sunday, September 17, 1978. The program will be held at the Continental Regency Hotel, 500 Hamilton Blvd., Peoria, from 9 a.m. until 4 p.m.

The symposium represents an annual culmination of daily efforts to define and disseminate an understanding of the nature and function of the medical office staff.

Physician-employers are asked to encourage their office staff to attend this diversified, educational program. The program, coordinated by the Peoria Chapter, is designed to be of interest to medical personnel in all capacities.

Application has been filed with the American Association of Medical Assistants for CEU (continuing education unit) credits.

Following registration and coffee at 8:30 a.m., the morning segment will be devoted to the importance of accurate medical record keeping in the doctor's office. A medical record instructor will explore the number one phase of record keeping: confidentiality.

A slide presentation on rare diseases of the ears, nose and throat will accompany a lecture on treatment and office care. The speaker for this

segment is a well known ENT specialist.

The afternoon segment following noon luncheon will deal with office surgery. Changes and improvements in general and thoracic surgery as well as handling the post surgical patient in the office will be discussed by a panel of prominent surgeons.

Miss Pauline Klarich, chairman, and members of the Peoria chapter will welcome registrants at a hospitality-welcome party on Saturday, September 16, 1978 at 6:30 p.m. in the hotel. Refreshments will be served.

Registration package includes refreshment Saturday evening, coffee/rolls Sunday morning and luncheon Sunday noon, in addition to the all day educational seminar.

Advanced registration for members before September 1, 1978 will cost \$12.50. Member registration after that date is \$15.00. Students will be charged \$6.00, and non-members, \$15.00. (Registrants are advised to contact the hotel in advance for overnight accommodations.)

Please complete the coupon below and mail to: Mrs. Mary Palmer, 1925 W. Calendar Street, Peoria, Ill. 61604. (309) 676-5438. Make check payable to: AAMA, Illinois Society, Symposium.

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Obituaries

****Alvarez, Walter C.**, San Francisco, California, died June 18, 1978, at the age of 93. He was a 1905 graduate of Cooper Medical College, San Francisco. Dr. Alvarez practiced medicine for 70 years, and formerly wrote a medical column for the *Chicago Sun-Times*.

****Bond, Ian H.**, Ormond Beach, Florida, died October 28, 1977 at the age of 80. Dr. Bond was a 1928 graduate of Rush Medical School.

****Colwell, Arthur**, Evanston, died June 14, 1978, at the age of 80. A 1922 graduate of Rush Medical College, Dr. Colwell was chairman of Northwestern University Medical School's department of medicine for 15 years. In his long association with Northwestern Memorial Hospital, Dr. Colwell practiced internal medicine and was named president of the American Diabetes Association in 1955. Dr. Colwell was a founder and president of the Chicago Diabetes Association.

***Elmer, Raymond F.**, Colorado, died June 4, 1978, at the age of 86. Dr. Elmer was a 1915 Chicago Medical School graduate.

****Garside, Earl**, Chicago, died June 7, 1978, at the age of 78. He was a 1923 graduate of the University of Oklahoma. Dr. Garside was a surgeon and former chief of staff at Augustana Hospital.

***Goldstein, I. Irwin**, Chicago, died May 23, 1978, at the age of 64. Dr. Goldstein was a 1939 graduate of Stritch School of Medicine.

***Hastings, J. W.**, Aledo, died June 5, 1978, at the age of 62. He was a 1942 graduate of the University of Illinois, Abraham Lincoln School of Medicine. Dr. Hastings had held many offices in the Mercer County Medical Society, and served as secretary at the time of his death. He was also the chief of surgery at Mercer County Hospital.

***Karg, Frank P.**, Western Springs, died May 18, 1978.

****Kenyon, Allan T.**, Chicago, died May 26, 1978, at the age of 77. He was a 1926 graduate of Rush Medical College. Dr. Kenyon was professor emeritus at the Pritzker School of Medicine. At the time of his retirement in 1966, Dr. Kenyon was head of the department of endocrinology.

Kirson, Celia, New York, died June 18, 1978, at the age of 85. Dr. Kirson was an attending psychiatrist at Manteno State Hospital.

***Lang, Theodore**, Rockford, died April 12, 1978, at the age of 73. He was a 1929 graduate of the University of Vienna, Austria. Dr. Lang was formerly affiliated with St. Ann's Hospital, 1933-1972, and served as head of the department of radiology.

****Lenit, Oscar**, Florida, died May 30, 1978, at the age of 88. A 1914 graduate of the University of Illinois, Dr. Lenit was formerly on the staff of American Hospital.

***Slaughter, Wayne B.**, Idaho, died June 21, 1978, at the age of 70. A 1934 graduate of the University of Nebraska and former Chicago surgeon, Dr. Slaughter served as a faculty member at Loyola University. He was also chairman of the department of plastic surgery at Mercy Hospital.

***Steinberg, D. Louis**, Elgin, died April 27, 1978, at the age of 75. Dr. Steinberg graduated from the University of Illinois in 1931.

***Strauser, Emory Ross**, Dixon, died May 16, 1978, at the age of 82. Dr. Strauser was a 1932 graduate of the University of Chicago, Pritzker School of Medicine.

****Sugar, Roy Thomas**, Chicago, died May 12, 1978, at the age of 82. He was a 1926 graduate of the University of Illinois, Abraham Lincoln School of Medicine.

***Suslick, Alvin**, Evanston, died May 22, 1978, at the age of 53. Dr. Suslick was a 1950 graduate of the University of Illinois.

****Thiell, James E.**, Rockford, died May 23, 1978, at the age of 87. Dr. Thiell was a 1915 graduate of the University of Illinois.

***Urban, Francis E.**, Chicago, died December 11, 1977, at the age of 71. Dr. Urban was a 1933 graduate of the Stritch School of Medicine.

****Welden, Edmund A.**, Summit, died January 21, 1978, at the age of 91. Dr. Welden was a 1917 graduate of the University of Illinois.

****Zaus, Earl Alfred**, Chicago, died April 21, 1978, at the age of 82. He was a 1922 graduate of Rush Medical School and was formerly affiliated with Cook County Hospital.

***Zeller, Michael**, Skokie, died November 5, 1977, at the age of 78. Dr. Zeller was a 1925 graduate of Northwestern University Medical School.

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***Indicates member of the ISMS Fifty Year Club.*

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Before prescribing Tofranil-PM, please review a summary of the prescribing information on the back of this page.

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As anxiety, agitation, sleep disturbances, and other depressive symptoms are relieved, mood and motivation may be markedly improved.

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Contraindications: The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hypertensive crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious, or even fatal. When it is desired to substitute Tofranil-PM, brand of imipramine pamoate, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

Warnings: *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed. Extreme caution should be used when this drug is given to:

- patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;
- patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;
- hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;
- patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;
- patients receiving guanethidine or similar agents since imipramine may block the pharmacologic effects of these drugs.

Since imipramine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as operating an automobile or machinery, the patient should be cautioned accordingly. *Usage in Children:* Tofranil-PM, brand of imipramine pamoate, should not be used in children of any age because of the increased potential for acute overdosage due to the high unit potency (75 mg., 100 mg., 125 mg. and 150 mg.). Each capsule contains imipramine pamoate equivalent to 75 mg., 100 mg., 125 mg. or 150 mg. imipramine hydrochloride.

Precautions: It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in

Geigy

Tofranil-PM encourages patient compliance because one capsule lasts from bedtime to bedtime.

Good results are usually seen at the starting dose of one 75-mg capsule h.s.

For many patients, dosage can be safely increased to 150 mg daily.

the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with Tofranil-PM, brand of imipramine pamoate, and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil-PM, brand of imipramine pamoate, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

Adverse Reactions: Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

Psychiatric: Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

Neurological: Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

Anticholinergic: Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosen-

As with all tricyclics, sedation may occur. Please caution patients against driving or operating dangerous machinery.

Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg of imipramine hydrochloride.

sitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia; purpura; thrombocytopenia.

Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

Gastrointestinal: Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though not indicative of addiction abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: In adult outpatients, therapy should be initiated on a once-a-day basis with 75 mg./day. This may be increased to 150 mg./day which is the dose level which usually obtains optimum response. If necessary, dosage may be increased to 200 mg./day. Dosage should be modified as necessary by clinical response and any evidence of intolerance. Daily dosage may be given at bedtime, or in some patients in divided daily doses.

Hospitalized patients should be started on a once-a-day basis with 100-150 mg./day and may be increased to 200 mg./day. Dosage should be increased to 250-300 mg./day if there is no response after two weeks.

Following remission, maintenance medication may be required for a longer period of time at the lowest dose that will maintain remission. The usual adult maintenance dosage is 75-150 mg./day on a once-a-day basis, preferably at bedtime.

In adolescent and geriatric patients, capsules of Tofranil-PM, brand of imipramine pamoate, may be used when total daily dosage is established at 75 mg. or higher. It is generally unnecessary to exceed 100 mg./day in these patients. This dosage may be given once a day at bedtime or, if needed, in divided daily doses.

How Supplied: Tofranil-PM, brand of imipramine pamoate: Capsules of 75, 100, 125 and 150 mg. (Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg. of imipramine hydrochloride.) (B) 98-146-840-A(9/75) 667120

For complete details, including dosage and administration, please refer to the full prescribing information

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Manuscript Information

The *IMJ* solicits original articles of clinical interest to the medical profession. Manuscripts should ordinarily be limited to 12-16 pages double spaced, with one inch margins. Case reports also are welcome; these, however, should be limited to 2,000 words (allowing equivalent space for charts and illustrations). Lengthy reviews of the literature also are welcome, but these may be serialized. Authors are requested to indicate an appropriate "breaking point" for long articles.

Up to twenty references will be published for clinical manuscripts; a maximum of ten are permitted for case reports. *Please follow Journal style in your references.* They should be numbered in order of appearance. The style is as follows: author name(s), article title, source periodical, volume, page, and date of publication.

The Journal cannot accept responsibility for accuracy of text or references.

The first page of each manuscript should show the title, authors, author degrees, positions, and mailing addresses. All manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations should be drawn in india ink or photographed as black-and-white glossies. Number illustrations consecutively and mark the top of each, as well as your name, on the back.

On the second page, please give a brief summary of content.

If you are not interested in writing an article for the *Journal*, why not at least communicate your thoughts and clinical notes to the "Membership Forum" section? And don't forget our new feature, "Ask A Consult," starting next month.

All correspondence should be addressed to: J. William Roddick, M.D., Chairman, IMJ Editorial Board, 55 E. Monroe Street, Suite 3510, Chicago 60603.

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Rheumatology Rounds

L. F. Layfer, M.D., and J. V. Jones, M.D., Contributing Co-Editors

Painful Anterior Shoulder Mass With Calcification

A 61-year-old housewife presented with a painful anterior shoulder mass. Four months previously she had noted onset of right shoulder pain while lifting groceries. The symptoms were exacerbated by forward flexion of the arm. Gradually range of motion became restricted in all directions due to severe pain, which localized anteriorly to a newly developed tender bulging mass. The pain was worse at night, especially when she slept on the shoulder, and would occasionally radiate down the outer aspect of the arm.

She denied a history of local trauma or unusual stress. Her right wrist had been fractured two years earlier, but healed without residual symptoms. She had no other joint complaints. Further past history and systems review were noncontributory.

On examination, a tender, compressible ill-defined swelling was present anterior to the coracoid process on the right. No heat or redness were noted. The short and long heads of the biceps were tender, and Yergason's sign (resistance against flexion and supination of the forearm designed to stress the biceps) was positive for tenderness localized to the mass. Active range of motion was less than passive range of motion in all directions, and both were limited by pain. Palpation of the deltoid, acromion, supraspinatus, infraspinatus and lateral pectoral areas revealed no tenderness. There were no axillary nodes. Other joints were normal to examination.

Laboratory

Sedimentation rate was 10 mm/hr. Rheumatoid factor was negative. SMA 18 and complete blood count were normal. X-ray of the right shoulder is shown in Figure 1. X-ray of the right wrist was normal.

Comment

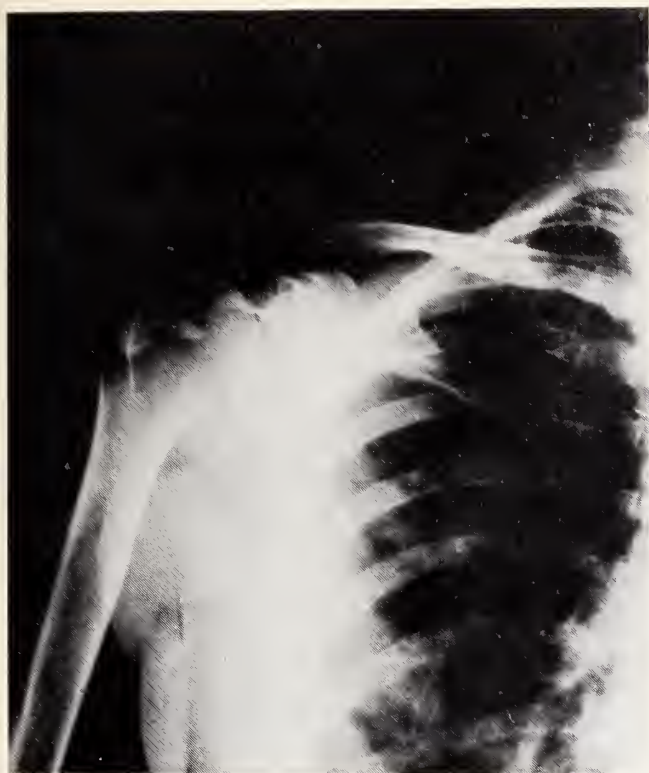
Calcium deposits in tendons, ligaments and

joint capsules are a frequent asymptomatic radiologic finding. Acute episodes of bursitis and tendonitis, and rarely, synovitis, are associated with such calcific deposits. Such deposits have been shown to be in the form of calcium hydroxyapatite crystals.¹ Deposits near the rotation cuff of the shoulder are those best known to clinicians. These occur in 3% of an unselected population.² They frequently give acute episodes of subacromial or subdeltoid bursitis with pain on abduction and tenderness under the acromial tip. Deposits are also commonly seen in other shoulder tendons,³ and near the greater trochanters of the hip.⁴ Smaller calcifications have been infrequently seen in tendons and ligaments near the wrist, elbow, knees, ankles and the interphalangeal joints of the hands and feet, where they may also cause inflammation.⁴

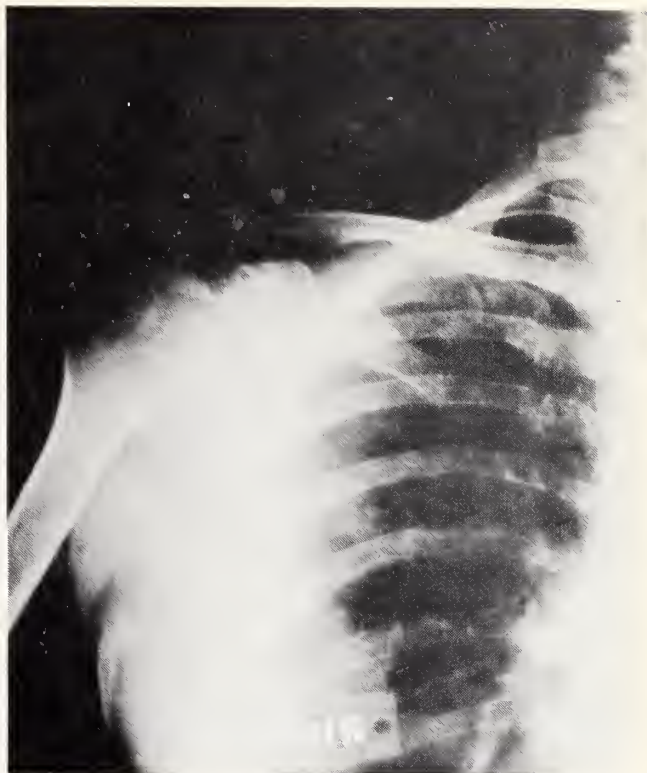
Attacks are heralded by pain and tenderness near the site of the calcific deposit, where a bursa may form. The reason why a dormant deposit suddenly causes onset of acute inflammation is not known. Apatite crystals, like urates, cause inflammation when injected into soft tissues, but may lie inert in some tissues for a time. Clinically the attacks may be acute and gout-like in nature⁵ or more local and chronic as in a "tennis elbow." A localized area of tenderness near the calcium is usually found, but pain on motion of the neighboring joint simulating intra-articular disease is frequent.

It is not known whether tendon degeneration precedes the deposits or vice versa. No metabolic or hormonal abnormalities have been demonstrated. Some patients have involvement of multiple sites and recurrent attacks suggesting some underlying systemic abnormality.⁶ Deposits have been found to cause gout-like attacks in patients on dialysis for chronic renal failure.⁷ This suggests a metabolic abnormality.

Oral anti-inflammatory agents may be tried but are generally ineffective. Aspiration of the bursa, if well defined, may result in calcium crystal removal and subsequent relief. Injection



A



B

Figure 1
The dense calcific deposit can be seen moving medially as the arm moves from external rotation (A), to internal rotation (B), placing the mass anterior.

of a lidocaine and steroid combination into the areas of tenderness usually results in prompt relief of symptoms and may be curative. Healing is often associated with spontaneous reabsorption of the calcium. Deposits may recur, and surgical removal may be necessary. Colchicine has been effective in the inflammation associated with chronic renal failure.⁷

Conclusion

Calcium deposit on X-ray lead to a diagnosis of calcific tendonitis in an unusual position, probably the short head of the biceps. The biceps tendonitis and anterior bursitis were thought secondary to apatite induced soft tissue inflammation near the coracoid where the short head of biceps inserts. A 22-gauge needle was placed into the ill-defined mass and 2 ml. of fluid containing chalky-white granules were removed. A lidocaine and steroid solution was injected into the area and brought rapid pain relief. Normal range of motion was restored, which demonstrated an absence of underlying adhesive

capsulitis (frozen shoulder) which sometimes accompanies such lesions. The patient had only minimal pain the next day, and on six month follow-up was entirely asymptomatic. ◀

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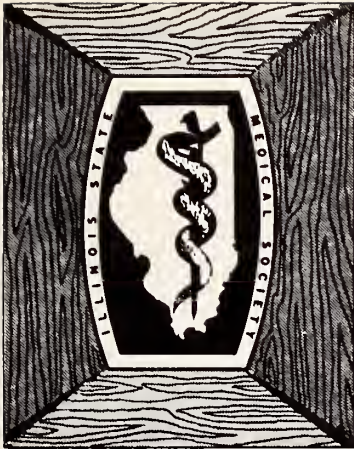
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Rape: A Community Hospital Study

PEDRO A. POMA, M.D. AND ROBERT C. STEPTO, M.D., PH.D./CHICAGO

Rape is a violent crime that has increased in incidence (Federal Bureau of Investigation—1975). Illinois Law (PA 79-564, effective January 1, 1976) mandated the Illinois Department of Public Health to prescribe minimum standards, rules and regulations for emergency care of alleged rape victims in Illinois.

Before the law became effective, private practitioners were not usually aware of the circumstances of rape and the requirements of rape victim management.

The records of women admitted for treatment to the Emergency Room (ER) at Mount Sinai Hospital Medical Center of Chicago between January 1, 1974 and December 31, 1975, have been studied carefully. Multiple variables were

noted and constitute the basis for this report. The hospital is located in Chicago's inner city.

During the study period, when an alleged rape victim presented in the ER, the ER nurse would guide her into a private room. Here the surgical resident evaluated her specifically for life-threatening conditions and extragenital injuries. The gynecological resident would then take a history and perform sexological examination, evidence collection, prophylaxis and therapy when indicated. The nurse remained in the room throughout the procedure. Other tests and specialty consultations were done when necessary.

Results

During the study period, 236 women were attended in the ER for the complaint of rape. The incidence of reported rape was higher during the summer months (mean 26) when compared to other months (mean 17). Age of alleged rape victims ranged from three to 47 years. Forty-five (19%) were younger than 16 and only two were older than 45; 114 women had never been pregnant.

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Time and Place

Rape allegedly occurs more commonly during the dark hours. In this study, 66 incidents were reported during daylight hours (6 a.m.-6 p.m.). Fifty per cent of all cases occurred in the street; 27% in the victim's home and 23% in a car.

Number of Attackers

According to the alleged victims, 29.6% (70) of the incidents were associated with multiple attackers, usually two (in 41 cases), but there was one case where 15 persons abused the victim. Of the cases studied, 166 reported a single attacker and nine reported multiple attacks. The attacks were vaginal only in 204 cases; there were nine oral or rectal intercourse attacks. In one case contact was only oral and 22 victims reported no penile insertion; ejaculation occurred at perineum. There were eight cases of incest and 54 of the victims knew their attackers.

Method

The method used by the attacker was recorded in 107 of the cases studied. In 43 cases there was either verbal threat to harm others (seven), or physical harm to the victim (36). In eight cases drugs and alcohol were used. Weapons were used in 56 cases (38 instances: guns; 13 instances: knives; two instances: candle holders and in three instances: bricks).

There were reports of seven cases in which either a girlfriend or boyfriend took the victim to the attackers. A rear-end collision was used to start contact with the victim in one case. In three cases the victim returned home to find a burglar; 15 victims told us that they were robbed following attack.

Interval

The interval between the alleged attack and arrival in ER ranged from 14 minutes to 65 hours. In 68 cases this information was not available. In 147 cases, the interval was shorter than five hours; in four cases longer than 24 hours. Eighty-eight percent of the women in this study were single; 159 alleged victims were accompanied to the ER by a female (usually the victim's mother) and 64 by a male (usually the victim's husband). Only 13 victims came for treatment alone.

Pregnancy Risk

At the time of attack 22 victims were premenarchal and 171 were at different phases of their menstrual cycle (18 were menstruating; 62 in the first half of their cycle, 10 at midcycle, 81 in the second half of the cycle). Pregnancy was diagnosed in 19 cases (14 at three months or less, one in the second trimester, and four in the third trimester). Six victims were in the postpartum period, three were postmenopausal and 15 had hysterectomy before the incident. Therefore, 176 victims were at risk of pregnancy. Of these women, 75.30% (128) were not using contraceptive measures when attacked; seven had been sterilized, and 35 were employing temporary methods of contraception.

Injuries Resulting from Attack

There was no evidence of physical injury in 136 cases; 42.37% suffered injuries (121 extragenital injuries and 49 genital injuries). In some cases more than one type of injury was sustained. Abrasions were more common than lacerations and hematomas.

Extragenital Injuries

Abrasions were more common on the upper and lower extremities, face and back. Hematomas were most often incurred in the face. Lacerations were present at the head, face, extremities and neck.

Genital Injuries

Abrasions were common in the vagina and vulva. Hematomas were seen usually in the vulva and lacerations were noted at the vulva, vagina and perineum. There were 25 cases where the hymen was described as intact; one of these women was pregnant, two others presented with the tail of an IUD evident.

Other

Severe psychological reaction was exhibited by nine victims, characterized especially by over stimulation and aggression. In five cases there was history of lost consciousness.

Severe injuries required hospitalization for three patients; one of these victims required blood transfusions. Alcohol intake was obvious in five cases and drug usage was admitted or suspected in three. According to relatives, two of the alleged victims had previous psychiatric treat-

ment. Mental retardation was evident in two cases.

Semen Studies

There was no information of semen evaluation in 121 records. Pelvic examination was not done (either because the alleged victim refused it or because of the young age of the victim) in 32 cases. Records for 83 illustrated the presence of semen—in 65 it was motile and in 18 semen was non-motile. Specimens were taken from the posterior vaginal fornix.

Venereal Disease Prophylaxis

There was no documentation of any therapy in seven records. Penicillin was used intramuscularly in 205 cases, tetracycline in 12, spectomycin in eight, erythromycin in four. There were five recorded instances of previous allergy to penicillin.

Pregnancy Prevention

There were 101 cases not at risk and one patient who refused prophylaxis against pregnancy. Seven had just menstruated and considered at no risk. Of the 127 patients who agreed to medication, 96 received ethylbestrol orally, 20 had progestins orally and 11 intramuscularly. There was no evidence of pregnancy in this group, but the follow-up has not been satisfactory.

ER Admission—Discharge Interval

This information was not available in 50 records. Three women were admitted to the hospital. In 137 cases the interval was less than two hours. In 42 cases the interval was up to four hours. During this period of time X-ray studies were done in 21 cases and superficial laceration suturing in 13 cases. Medical consultation was required in three cases (i.e. glucosuria) and psychiatric consultation was necessary in four cases.

Discussion

Rape is one of the least reported violent crimes, probably because social pressures and up-bringing place the victim (usually female) in a very difficult situation and holds her responsible for the incident. This is exacerbated when, as in most instances, she is the only witness or may have previously met the assailant, or dated him. Due to social stigma attached to this crime, rape is almost never reported in more affluent com-

munities. We hope women who do not report assault are aware of the consequences and obtain appropriate care and counselling.

Rape can happen to anyone, at any age or place, but the recorded incidence is usually higher during reproductive years. In this study only 19% were younger than 16 years. Massey¹ reported 24%, Hayman and Lanza² 36%. The assault occurs commonly in the victim's home, and very rarely at a friend's home. In the latter situation the victim may have more difficulty in establishing her claim.

The approach or techniques used by the attacked or attackers are multiple, according to Burgess and Holstrom,³ and on some occasions a known or trusted person escorted the victim to the attackers. In other cases rape followed another intended crime, e.g., burglary. Often enough the rape is committed by more than one aggressor. Women in this study were aware of the need for medical services; most of them came to our ER within five hours. This is the ideal time for detecting motile sperm and to initiate other therapy or prophylaxis. Others were held by their assailant and/or were not aware of the services provided.

The authors stress the individual's right to seek and receive these services and treatment even if the "victim's decision" is not to report the incident to the authorities.

The evaluation of menstrual status and contraceptive measures in our study group revealed a need for prophylaxis in relation to unwanted pregnancy, even when the risk is small. Most of these patients agreed to medication to temporarily change the condition of their endometrium and prevent nidation, and also penicillin for VD prophylaxis. Injuries noted were 71% extragenital, 29% genital. Extragenital injuries were more common, Burgess and Holstrom³ reported 60%, Robinson 29%⁴ and Massey 10.6%.¹ Genital injuries were 39%, 8.5%, and 5.2% in those series, respectively.

Rape is not a medical diagnosis. The court decides if rape occurred. The presence of semen is not legally required to establish rape. Members of the health team have responsibility to provide evidence. The ability to collect this type of evidence must be reinforced because it is not usually taught. The collected specimens must be properly identified and handled according to a very rigid protocol if they are going to have any value in court. The presence of semen can establish the fact that intercourse happened sometime before examination. The problem remains for

the courts to decide if this occurred voluntarily. G. F. Sensabaugh⁵ reported that gelelectrophoresis evaluation of seminal enzymes may facilitate individual identification with 95% probability. Under the present court system, the alleged assailant may refuse the testing.

We consider the treatment provided at our institution efficient and expedient, with medical and psychological needs attended. The prophylaxis for venereal disease appears satisfactory, but the severe secondary effects of commonly used medications to alter the condition of the endometrium to prevent nidation do not. The use of intramuscularly administered progesterin or parental estrogens may be more appropriate, but there is still the possibility of secondary effects in a few cases and patients should be made aware of the reported association with congenital malformations.

The victims advocacy program appears the most important step into complete victim management. The feminist movement, the establishment of "sex squads"—vounteer citizen groups providing protection, counselling and 'hot lines'—and increased societal awareness have all improved the handling and reporting of this crime.

Regular meetings of concerned health team members involved in the counselling and management of rape victims may further improve their standard of care. There has been such a program initiated in this institution. Complete eradication will require successful treatment centers for the aggressors, and societal attitudinal changes in relation to sexual attitudes and stereotyped roles.

Sex is something one does *with* another person, not *to* another person. Rape is a violent crime; an aggressive act that violates the rights of another person. ◀

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A New Approach

Bedside Barium Enema

BY SAMUEL C. BALDERMAN, M.D., KRISHNAN SRIRAM, M.D. AND
ARTHUR G. MICHEL, M.D./CHICAGO

The general surgeon is often confronted with a patient who has massive lower gastrointestinal bleeding and presents diagnostic and therapeutic problems. The typical patient is an elderly individual who is brought to the emergency room by his relatives, or is transferred from a nursing home. He or she may be in poor physical condition with low blood pressure and thready pulse. After preliminary resuscitative measures in the ER the patient is transferred to the intensive care unit while preparations are made for diagnostic studies such as barium enema or an angiogram. A proctoscopy is, of course, done first.

In many instances the patient's poor general condition precludes transport to the radiology department for diagnostic studies. We suggest in this communication the use of barium enema at the bedside. The procedure is simple to perform and is often diagnostic and therapeutic.

A catheter with a 30cc balloon is introduced into the rectum and the bulb inflated with normal saline or air. About 1500 to 2000cc of the barium solution is slowly introduced and the patient closely observed for any discomfort. Caution must be exercised to avoid perforation of the bowel. The patient is sequentially rotated from a left lateral to supine and right lateral positions. The plastic bag with barium solution is kept at a height of four feet from the bed. A

scout film of the abdomen is taken with catheter still in place.

The barium solution is empirically left in the colon for 60 minutes. Then the plastic bag is placed on the floor to facilitate re-collection of the solution. The balloon is deflated and catheter removed.

A post-evacuation film may also be obtained.

Case One

A 79-year-old white male was admitted to the hospital with a 24-hour history of lower gastrointestinal bleeding. It was his first episode of this nature.

The patient had a history of atrial fibrillation and left cerebrovascular accident some months before admission. The condition had since partially resolved and he was on digoxin and quinidine.

Physical examination revealed a frail, elderly individual with a pulse of 120/minute and BP of 90/60 mmHg. There was tenderness without rebound in the left lower quadrant. Rectal examination revealed fresh blood and blood clots but no mass. A naso-gastric tube was inserted; the aspirate was clear. The patient was initially managed in the ward. However, massive rectal bleeding continued and the hematocrit remained at 25% despite rapid blood transfusion. The patient was transferred to the intensive care unit at which time he continued to be tachycardic with a systolic BP of 60 mmHg. His hemoglobin was 7.6 Gms% and hematocrit 24%. EKG was

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Figure 1

Photograph of bedside barium enema showing multiple diverticuli in the descending and sigmoid portions of colon.

read as "acute coronary insufficiency."

Proctoscopy was difficult and inconclusive because of excessive bleeding. Angiography was deferred because the patient was elderly, in shock and obviously had severe atherosclerosis (previous history of cerebrovascular accident).

Barium enema was administered at the bedside and the roentgenogram showed multiple diverticuli in the descending and sigmoid portions of the colon (see Figure 1). The bleeding stopped soon after administration of the barium solution. The patient had received 5 units of blood.

He continued to improve. There was no recurrence of bleeding. He was discharged without elective surgery.

Case Two

A 66-year-old black male, a known alcoholic with a previous history of myocardial infarction, was admitted to the intensive care unit with a two-day history of passing bloody stools.

The stools were described as containing both bright red blood and maroon-colored clots. His past history was unremarkable except for appendectomy in childhood.

Upon admission his blood pressure was 90/60 mmHg and pulse 140/minute. Hemoglobin was 14.4 Gms% and hematocrit 43%. Prothrombin and partial thromboplastin times were within normal limits. The gastric aspirate was clear.

Gastroscopy done the next morning revealed a duodenal ulcer at the apex of the duodenal bulb. The ulcer was not actively bleeding and there were no varices. The nasogastric tube was not re-inserted after gastroscopy. The patient was started on oral milk and Maalox®.

Proctoscopy at bedside showed fresh blood and maroon-colored clots in the rectum but was otherwise negative. Bedside barium enema showed no mass lesions or diverticuli.

Bleeding per rectum continued on the second day after admission. Hemoglobin fell to 8.5 Gms%. A total of 10 units of blood were administered over a period of 16 hours. Pulse rate persisted at 120/minute. It was decided that surgery was necessary. At surgery, a bleeding duodenal ulcer was found. Partial gastrectomy with Billroth II anastomosis and vagotomy was done. The post-operative course was uneventful.

Discussion

Localization of bleeding within the gastrointestinal tract can be very taxing. While proctoscopy and barium enema are useful in the localization of a lower GI bleed, angiography is most accurate.¹ Nusbaum and associates (1969) have clearly demonstrated the safety and usefulness of percutaneous retrograde angiography in localizing bleeding of as little as 0.5 ml/minute.² However, in an elderly patient with multiple medical problems, especially atherosclerosis, angiography may be contraindicated. The success rate in such patients is also poor.³ In such an event, barium enema is a useful alternate diagnostic measure. Needless to say, if angiography should follow barium enema the retained barium makes the radiologist's task very difficult. The latter should therefore be done only after deciding not to perform an angiogram.

While the most common cause of all rectal bleeding is carcinoma, massive rectal bleeding is most often due to diverticulosis.⁴ Fortunately, compared to other lesions like polyps, diverticulosis is easily demonstrated radiographically. Barium enema will not usually identify the site

of bleeding but the presence of diverticulosis influences subsequent patient management.

Barium enema can be therapeutic, as illustrated by Case One. Adams (1970) reported cessation of massive rectal bleeding after the use of barium enema in 26 out of 28 episodes in 22 patients.⁵ While there is no clear explanation for this effect, two factors may be considered, namely, pressure by the barium solution producing tamponade and a direct hemostatic action by the barium sulfate. The former seems more probable, as the effect is often immediate. It has been calculated that an intraluminal pressure of about 90 mmHg is produced when barium enema is administered.⁶ As hydrostatic pressure is the most likely reason for the therapeutic effect of barium enema, it seems justifiable to use saline instead of barium solution if angiography is contemplated.⁷

Once rectal bleeding is controlled the patient can undergo a thorough gastrointestinal work-up with no urgency. Elective surgery was not done on Case One because of his poor general condition, though others believe that it should be done.^{8,9} However, if the patient continues to bleed, emergency laparotomy must be performed without undue delay.

The technique of bedside barium enema helped considerably in the management of these two patients. In the first patient, diverticulosis was revealed and the procedure stopped the bleeding. In the second patient, a diagnostic problem, the presence of a lower gastrointestinal lesion was ruled out with reasonable certainty.

To summarize, although ideally performed in the radiology department, barium enema can be easily and safely performed at bedside even in poor risk and unstable patients. It helps considerably in pre-operative evaluation and is therapeutic in many instances. It is our hope that bedside barium enema examination might be used more often. ◀

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Pediatric Perplexities

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The Pediatric Perplexities series analyzes slightly uncommon pediatric disorders which require prompt diagnosis and specific management modalities. The editor welcomes suggested topics and questions from interested readers.

Organophosphate Poisoning

BY IQBAL A. MEMON, M.D./CHICAGO

Accidental ingestion of poisons is a major pediatric problem and cause for hospitalization. The vast majority of toxic ingestions can be managed only with general supportive measures for there are often no specific antidotes. The pediatrician must know those potentially lethal compounds for which a specific antidote exists and can be life saving. Ingestion or contact with organophosphorous materials can be rapidly fatal, and produces a specific group of signs and symptoms that when recognized clinically allow for accurate diagnosis and immediate institution of appropriate antidotal therapy.^{1,2}

A 14½ month old black male was brought to the emergency room of Cook County Hospital by his mother approximately five hours after he had ingested an "ant killer." The solution, contained in a soda pop bottle in the bathroom, had been borrowed from a neighbor's large container. The child simply picked up the bottle and ingested an unknown quantity. Approximately 30 minutes later the child vomited and his mother gave him some milk. Three hours after ingestion it was noted that the child had noisy and rapid respirations. He became lethargic and was brought to the emergency room.

Physical examination revealed a comatose child with copious secretions from the pharynx, mouth, and nose. He was not responding to painful stimuli and the pupils were markedly miotic. Blood pressure was 114/42 mmHg, pulse 160/min regular, and respiratory rate 50/min. The patient was flaccid with an occasional

fasciculation of voluntary muscles. The deep tendon reflexes were absent. Coarse rales were heard throughout both lung fields.

The diagnosis of organophosphorous poisoning was suspected and the child was admitted to the pediatric intensive care unit. Intravenous fluids were started, he was given oxygen, suctioned and placed on continuous EKG monitoring. Intravenous atropine 0.05 mg/kg was repeated every 15 minutes for a total of 5 doses until the clinical signs of atropinization, fever, urinary retention, and dilated pupils were evident. An additional three doses of the atropine sulfate had to be given at approximately six hour intervals. The indications for subsequent atropine administration were the reappearance of miosis and decrease in alertness. Pralidoxime in a dose of 20 mg/kg was administered intravenously along with the third dose of atropine and with the sixth dose of atropine (six hours after admission). The child showed progressive improvement in the level of consciousness and increase in motor tone. The first effects of therapy were noticed following the third dose of atropine and the first dose of Pralidoxime. This

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therapy was continued as the patient began to do well and vital signs remained stable.

Blood for toxicological analysis confirmed organophosphorous compound ingestion by the determination of the cholinesterase level of 15 Rappaport units, the normal being greater than 50 units. This was subsequently substantiated by the mother who was able to locate the original container. It listed an organophosphorous compound.

Second Case Report

A 21-month-old black male was brought to emergency room of another hospital after drinking an unknown "roach spray." The "roach spray" had been borrowed from a neighbor and placed in a bottle which was left near the bathtub. The child picked up the bottle and ingested an unknown quantity. The original container had been discarded by the neighbor. Within 10-15 minutes the child began to gag and started to drool. Soon he became drowsy and was rushed to the nearest emergency room where he was found to be semi-comatose approximately 30-minutes after the ingestion. They noted copious secretions from the mouth and heard rales throughout the lung field. Gastric lavage was performed with normal saline, and intravenous fluids started prior to transfer to our hospital. Upon arrival 3½ hours after ingestion he was comatose, barely responded to painful stimuli, and had copious secretions from the mouth and nose. The child had three watery stools within ten minutes of arrival.

Physical examination revealed a blood pressure of 110/70 mmHg, the pupils were equal but pinpoint in size. Extremities were flaccid and voluntary muscles fasciculations were noted. The deep tendon reflexes were absent. The previously noted rales were heard throughout both lung fields.

The child was admitted to the pediatric intensive care unit where he was intubated and suctioned thoroughly. Continuous EKG monitoring was established. Atropine sulfate was administered intravenously and repeated at 15 minute intervals for three doses. Pralidoxime was also given with the subsequent atropine doses at three and six hours after admission. The patient was maintained on a respirator because the blood gas determinations showed anoxia and acidosis accompanying an irregular and inadequate respiratory effort. After institution of the atropine and Pralidoxime the muscle fascicula-

tion stopped, muscle tone increased, and the level of consciousness improved. After six hours the child was extubated and thereafter maintained normal blood gas tensions without ventilator assistance.

Because of the admission for ingestion a routine whole blood lead level was done, which was 80 micrograms percent and he subsequently received a course of chelation therapy with calcium EDTA and dimercaprol (BAL).

Discussion

There are many varieties of alkyl-phosphate compounds which are highly toxic due to phosphorylation which inhibits the enzyme acetylcholinesterase.² This leads to accumulation of acetylcholine at the autonomic cholinergic nerve endings, both peripherally and centrally. The net result is continuous stimulation followed by inhibition. Organic phosphate compounds are readily absorbed through the intact skin, by inhalation through the lungs or absorption through the gastrointestinal tract. Doses as low as 0.1 mg/kg of parathione (a common insecticide on farms) have been lethal.³ These compounds are used in the manufacture of a multitude of insecticide products which are widely used in homes and on farms.

The signs and symptoms of organophosphate poisoning occur within minutes or hours, but may be delayed up to 24 hours after exposure. The severity of the symptoms depends upon the amount of enzyme inhibition, which can be confirmed by an assay of serum cholinesterase activity. However, one does not need the laboratory diagnosis, in the presence of the signs and symptoms, to make the diagnosis and institute therapy. The signs and symptoms of organophosphorous poisoning are the results of effector sites stimulation of cholinergic centers. These include the central nervous system, somatic nerves, ganglionic synapses of the autonomic nerves, the para-sympathetic nerve endings, and sympathetic innervation of the sweat glands. The initial symptoms are due to over-stimulation which is followed by paralysis. Major signs and symptoms are summarized in Table 1.

For a successful outcome one must maintain good tissue oxygenation, which may require intubation and respiratory support in addition to frequent suctioning. One must avoid further exposure, and attempt to remove the organophosphorous by gastric lavage if it was ingested. The skin must be washed thoroughly if ex-

Table 1*
SIGNS AND SYMPTOMS OF
ORGANOPHOSPHATE COMPOUND POISONING

EYE	Decrease in intraocular pressure
Pupils	Miosis
Lacrimal glands	Increased secretion
Bronchial tree	Bronchoconstriction, dyspnea increased secretions, cough, cyanosis pulmonary edema
Cardiovascular system	Bradycardia, decreased cardiac output, hypotension, blood vessel dilation except for pulmonary and coronary vessels
Gastro-intestinal System	Vomiting, cramps, watery and explosive diarrhea
Sweat glands	Increased secretions
Salivary glands	
Urinary bladder	Frequent-voiding
Sympathetic ganglion	Tachycardia, elevated blood pressure
Skeletal system	Fasciculation, decreased muscle tone
Central nervous system	Restlessness, tremor, drowsiness, generalized weakness, coma, absent deep tendon reflexes, respiratory center depression

*Modified from Namba, *et al.*²

posure occurred through cutaneous contact. Atropine sulfate is given intravenously in a dose of 0.05 mg/kg and should be repeated every 15 minutes, along with continuous electrocardiogram monitoring for arrhythmias.⁴ Atropine is required in exceedingly large doses in this ingestion as compared to the atropine requirement for usual clinical states. When atropinization is achieved (as indicated by dilation of the pupils, tachycardia, dry mouth, and hot flushed skin) the further doses of atropine are withheld until symptoms recur. It is important to correct any hypoxemia or acidosis, as their presence increases the risk of ventricular fibrillation secondary to the atropine therapy.

The specific antidote, pralidoxime, not only prevents but reverses phosphorylation of the acetyl-cholinesterase enzymes. This drug is used as an adjunct to atropine and is not a substitute. Pralidoxime is a quaternary amine and thus does not cross the blood brain barrier. For this reason, it is not thought to ameliorate the central nervous system effects of organic phosphorous compounds.^{1,5-7} However, recent studies indicate the presence of a low concentration of pralidoxime in the central nervous system.⁸ Clinical observations of prompt recovery from coma and control of convulsions in cases of organophosphorous poisoning following the use of pralidoxime provides some evidence against the earlier speculation that it did not enter the central nervous system.^{9,10} The drug is usually admin-

istered intravenously in a dose of 10-12 mg/kg. Although it can be given intramuscularly, the absorption time may vary, which is why the preferable route of administration is intravenous. The dose may be repeated at one or two hour intervals or may be given by a continuous drip of 0.5 mg/hour until all symptoms are resolved. Side effects are very uncommon with the therapeutic dose. In unusually high doses, they are manifested by nausea, dizziness, diplopia, and impairment of accommodation. In the desperately ill child with organophosphorous poisoning these side effects are not a major drawback.

When managing a case of acute organophosphorous ingestion, it is important not to administer any other drugs which will potentiate the toxicity of the organophosphorous compounds, such as narcotics, phenothiazines, and theophylline derivatives.¹¹

Further Considerations

One must remember that symptoms may recur after the patient responds to atropine and pralidoxime. It is not unusual, as was observed in our patient, to require additional doses at 3-6 hours following initial response. These patients require close monitoring for an additional 24 hours after the last dose of atropine and pralidoxime. The toxicology laboratory can be invaluable for diagnostic confirmation. Organo-

phosphorous compounds may be detected in the gastric lavage, urine, or clothing. The primary blood test used to determine organophosphorous poisoning is the serum cholinesterase level. Remember the toxicology laboratory will be much more efficient in confirming the diagnosis if the signs and symptoms are listed on the laboratory requisition, or if they are aware that organophosphorous poisoning is suspected. The determination of cholinesterase levels in the serum and in the erythrocytes is the major confirmatory test. The cholinesterase levels within the erythrocytes are more accurate and are the preferred method, but they are technically more difficult and expensive to do. The serum levels are more simple and the results more readily available. A normal cholinesterase level excludes organophosphorous poisoning. The clinical signs and symptoms of organophosphorous poisoning do not occur until after 50% of the cholinesterase enzymes have been inactivated.² Levels in the 20%-50% range of normal would indicate mild poisoning; 10%-20% moderate, and less than 10% severe poisoning. Correlation is seen only early in the disease because during the recovery phase the cholinesterase levels rise rather slowly.

Nevertheless, the clinical signs and symptoms are so distinctive that the laboratory is merely a confirmatory test and not needed for clinical management.

Final Remarks

In both our patients, the material was obtained from a neighbor or friend. Subsequent questioning determined that the insecticides had originally been packaged in large containers intended for use by exterminators in houses and apartments. Buying it in bulk provides a much cheaper source than the brand name products which are available in small household packages. In both cases, a friend or neighbor generously loaned the family some of their "left over" insecticides and these were placed in soda pop bottles and left in situations where children could easily pick them up. These patients dramatically point out that ingestion in children tragically occurs because the toxic substances that are placed in containers are designed to hold food and beverages. Part of modern pediatrics should include parental instruction on prevention of ingestion as part of routine health maintenance. Such discussions should include not only where to keep toxic substances and safety latches, but also the danger of unlabeled compounds in soda pop bottles. ◀

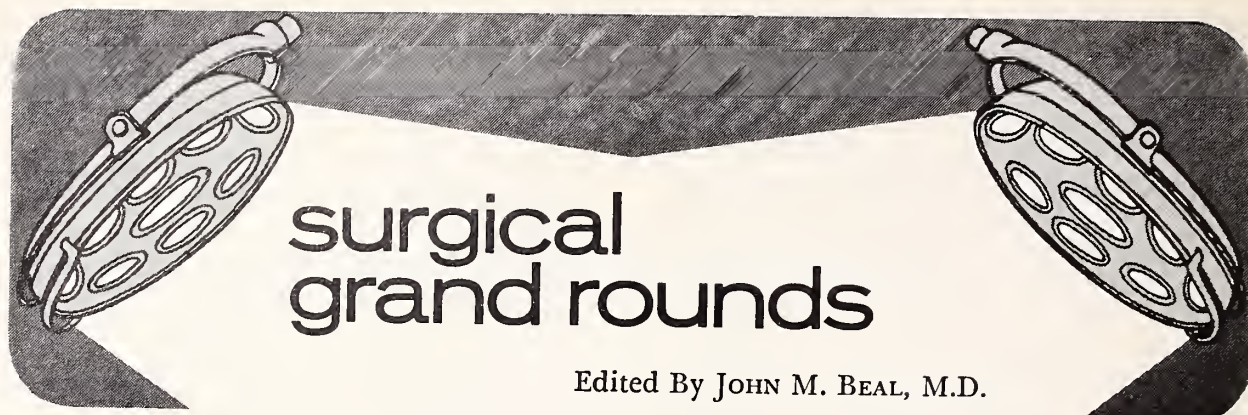
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ISMS Travel Program

Only one of the ISMS travel programs scheduled for 1978 remain open for reservations: the Eastern Mediterranean Air/Sea Cruise (Oct. 25-Nov. 7). Information on the 1979 programs will appear in the next issue.

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Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 17, 1978.

Case Report

Coronary Artery Surgery

Dr. John Beal: One of the most exciting recent medical developments has been the introduction of coronary artery surgery, but it has brought considerable controversy. A current series of publications has left uncertainty in the minds of many as to the real value of coronary artery bypass, an operation that is being done with increasing frequency. Doctor Michaelis has assembled a panel to discuss the merits of coronary artery bypass, the issues in the controversy, and to analyze the effectiveness of bypass surgery in coronary artery disease.

Dr. Lawrence Michaelis: Coronary artery bypass, in which a segment of saphenous vein is used to bypass obstructed coronary arteries, will be performed approximately 70 to 80 thousand times in the United States this year. The cost is, of course, staggering; however, the implications of the operation are also staggering. Before I discuss the surgical indications, I shall review the surgical anatomy of coronary arteries.

Normal coronary artery anatomy is variable. We usually talk about three major coronary arteries because the left main coronary artery bifurcates early. It provides a left anterior descending coronary artery and a circumflex coronary artery, which distribute vessels to the lateral border of the left ventricle. The right coronary artery is dominant in about 70% of the population. Dominance in the right coronary artery depends on the blood supply to the posterior interventricular septum. The posterior descending coronary artery, which in 70% of people is the terminal branch of the right coronary artery, supplies the back of the left ventricle. For all practical purposes, blood supply to the right ventricle is not very important; there is enough collateral in most people with normal pulmonary artery pressure so that complete occlusion of the right coronary artery can occur without much damage to the right ventricle. From the practical standpoint, we are considering the left ventricle

only. About 15% of the population has a dominant left coronary artery and their right coronary artery is not important in terms of the physiology of their ventricular contraction. An additional 15% or so of the population has a balanced circulation. When we talk about triple vessel disease, we refer to the left anterior descending coronary artery, the circumflex coronary artery and its branches and the posterior descending.

Operative Indications

When is the operation indicated? There are several things upon which even the most conservative cardiologists will agree. (1) The operation relieves pain by revascularizing ischemic myocardium. There have been a number of placebo operations or operations with questionable value. Suffice it to say the Vineberg operation (internal mammary artery ligation) and the Beck procedures (sclerosing of the epicardium) were said to relieve pain. They were very powerful placebos, but were not nearly as effective as coronary artery bypass in relieving anginal pain. Probably somewhere between 90 and 95% of the people who have coronary artery bypass have either complete relief or great improvement in their angina. The high incidence of occluded grafts in people with persistent pain provides further evidence that the revascularization itself is the reason for the relief of their pain. Most people with recurrent angina have occluded grafts.

The surgery is also indicated for significant obstruction of the left main coronary artery. A number of studies have attempted to randomize patients. Significant obstruction of the left main coronary artery is the finding that ends the random nature of the analysis. Infarctions caused by obstruction of the left main coronary artery are very often fatal. Left main coronary obstruction accounts for only five to eight percent of coronary disease cases, but it is an important consideration and one that should be excluded from any consideration of medical management.

Thirdly, the operation is indicated in unstable angina with impending myocardial infarction. This is the most questionable category because, like cardiogenic shock, unstable angina must be defined. By definition, unstable angina is any change in previous stable angina. Certainly, when there is good indication that a myocardial infarction is imminent or that the angina pattern has changed to such an extent that medical

management is not relieving it, almost all cardiologists concur that the operation is indicated.

Contraindications

When is the operation not called for? The operation is *not* indicated in two situations. The operation does not improve ventricular function. In other words, you cannot revascularize dead muscle. This does not mean that the operation was not indicated in the presence of left ventricular dysfunction, but it is not indicated *per se* for revascularization. It does not improve ventricular dysfunction caused by previously infarcted muscle. The operation is not indicated in the presence of diffuse small vessel disease. Adequate distal runoff is essential to perform bypass grafts.

There are two basic situations in which the operative indications are still uncertain. These are cardiogenic shock and whether the operation prolongs life.

Cardiogenic shock is, once again, also open to definition. There are people who have reported very good results in cardiogenic shock and others have reported dismal results. The few centers that are attacking cardiogenic shock vigorously with clear criteria have survival rates in the range of 20-30%, which is a very high mortality rate. They are operating under the assumption that their patients are going to have a much higher mortality rate without an operation. This is a major commitment for a medical center to take when studying cardiogenic shock.

The problems nationwide have been homogeneous criteria for cardiogenic shock and the timing of the operation. Statistically, it has not been proven that the operation is indicated. The overwhelming question, however, is whether or not coronary artery bypass grafting will prolong life. This seems like a very simple question.

The first problem is to find a prospective randomized study and a number of such studies have been proposed. We were involved in a 1972 study at the National Institutes of Health. Our results were typical.

The study was set up so the people were randomized after they had been studied. Those randomized to the operative groups said, "Thanks, great, go along with the operation." People who were randomized to the medical group said, "Thank you very much; I'm withdrawing from the study," and went someplace else to have an operation. We are not at the point where people

want the operation when they have angina and will not stay in the studies.

Risk Considerations

Next, I want to discuss the risk consideration in coronary artery disease. What increases the surgical risk. First, obviously, is the extent of the coronary artery disease, as well as anatomical and technical considerations in performing the operation. These were more formidable four or five years ago than they are now, because the operative technique itself has improved. Next is left ventricular function. Obviously, if someone has a very good ventricle, he is going to tolerate the operation better than someone with very marginal left ventricular function. We assess left ventricular performance preoperatively by a number of means, ventriculography, ejection fractions, left ventricular end-diastolic pressure and presence or absence of congestive heart failure.

Associated heart disease is another factor. If someone has a ventricular aneurysm and mitral regurgitation, he is at higher risk. Consider the condition of the patient's angina—has it been stable, or has it been unstable? Recent myocardial infarction is another factor. There is evidence that the operation's risks increase tremendously if you operate within four to six weeks of a myocardial infarction. We make every effort to postpone surgery in people who have had a recent myocardial infarction.

Finally, the skill of the surgical team is important. The team includes scrub nurses, pump technicians, operating room circulating nurses, house staff and surgical intensive care unit nurses. It has been very clearly shown that in centers where the whole team has cared for these patients on a regular basis, and the operation is done with frequency, better results are obtained than when the operation is done sporadically.

Pertinent Research

An article from the *New England Journal of Medicine* based on a cooperative study with the VA has caused wide comment. In this VA study, 310 patients were in a medical group and 286 patients were in a surgical group. This was a prospective randomized study carried out in seven or eight VA centers throughout the United States. All patients agreed to stay in the study. All patients had angiographic evidence of significant obstruction of one or more coronary arteries. This was defined as a 50% reduction in

lumen diameter, which is supposed to equal 75% reduction in cross sectional area of a vessel. Therefore, all had radiographic evidence of at least one obstructed coronary artery.

The VA study involved only chronic, stable angina. All of the standard surgical criteria were excluded. Excluded patients were those with any kind of myocardial infarction the last six months, any question of unstable angina, congestive heart failure in the last three weeks, any kind of associated heart disease, severe diabetes, hypertension in which the diastolic blood pressure was greater than 100 on therapy, and significant left ventricular dysfunction. The people in the study had good ventricles and chronic stable angina. The results three years after the operation were identical, in this VA study, for the surgical group and for the medical group. This is what has been presented in the newspapers.

But there are some considerations about the VA study that are very clear and are very important. The first real consideration is the number of grafts that were performed in these patients. This study is now three years old and showed an average of 1.9 bypasses per patient and no patient received more than three grafts. In most centers today, the average number of grafts performed is greater than 2.5 and it is not unusual to perform four or five bypass grafts in a patient in an effort for complete revascularization.

The next objection to the VA study is graft patency. In the VA study, 69% of all the grafts studied postoperatively were patent. Twelve percent of the patients had no patent grafts at all. Nineteen percent of the single bypass patients had occlusion of their grafts. Most centers reported over 85% in graft patency. As high as 88% has been recorded 6 to 12 months postoperatively and I would say 92 to 95% of patients should have at least one patent graft. The graft patency in the VA study is unacceptable by present cardiac surgical criteria.

The VA study reported an operative mortality of 5.6%. The surgical risk in this group of patients should have been 1 to 2% because patients with unstable angina, left main disease, recent myocardial infarctions and left ventricular dysfunction had been eliminated. By their criteria, in the last two years, we have not lost a patient in this hospital in people with chronic stable angina. Thus, a very high operative mortality rate was reported for this group of VA patients. Of course, that high mortality rate affected the

initial survival.

Another objection to the VA study is their statistical techniques. Seventeen percent of the original patient population selected for medical therapy experienced worsened symptoms and were transferred to the surgical group. If they died, they were considered surgical deaths, not medical deaths. These patients were considered lost to follow-up for the medical group.

In addition, the VA study failed to mention a large subgroup. The largest subgroup of the VA study were people with triple vessel disease and some left ventricular dysfunction. These patients were presented to the American Association of Thoracic Surgery in 1977. Survival of 85% in the surgical group and 76% in the medical group was reported at 54 months. This is considered statistically significant. The editorials made no mention of the finding that the triple by-pass patients with some left ventricular dysfunction had a statistically significant better chance after operation than they did after medical therapy.

With that background, Doctor Lesch will continue the discussion from a cardiologist's viewpoint.

Dr. Michael Lesch: The search for absolutes in the press and among ourselves has led to polarization, which I think has been counter-productive. There is to my knowledge no study in the medical literature which *proves* the value of penicillin therapy in pneumococcal pneumonia. It was so obvious and that was that. There is a lot invested in coronary surgery and I would like to go through some philosophical approaches. The data is the same. Rather than be a proponent or an opponent, I would like to look at this in a rational way and try to tell you as a practicing cardiologist what we do in a center where very good surgery is available.

The left main coronary disease issue should be put to rest. There is no question that surgery is the therapy of choice there.

The issue about the treatment of intractable pain has been met by the surgical/medical cardiologic community with the appropriate answers. Surgeons and cardiologists have shown that the operation is unequivocally the best available treatment for angina or is certainly a very adequate substitute for drug therapy which frees the patient of a number of constraints. It is society's duty to determine whether that's worth \$15,000 per patient. That is, if in fact we're talking about the distribution of medical resources

and the government does what they did in Canada. There they say essentially: "We have X million dollars of money for medicine. Doctors, you decide how you are going to spend it." Then the discussion departs from the medical point of view and becomes a socio-economic discussion.

I think there is no question that the operation is the most effective treatment of pain. The story of placebos should be put to rest. In all of the previous operation, etc., the placebo effect usually lasted less than three months. In the studies that have been reported today on coronary patients, pain relief clearly lasts for more than three months—it lasts for years. The results are not due to placebo effect.

There are also people who say that their surgery is successful because it interrupts perivascular nerves. They conclude that any operation should be successful, whether it is successful grafting or not. This simply has not been proven. Probably the major objection is that approximately 50% of those patients reporting complete symptomatic relief, who have all grafts patent at recatheterization, have persistently positive exercise tests. Those who are familiar with any exercise testing know that there are about "25 pat reasons we will give for false positives." I simply interpret this as another reason for a false positive.

An interesting study at the recent American Heart Association meeting showed that examination of all exercise tests—isolating everybody with a positive test—uncovered 15 or 20% "false positives" insofar as ischemic heart disease was concerned. But if you look at the broader picture of heart disease, left ventricular hypertrophy due to hypertension, aortic valve disease, mitral valve disease, cardiomyopathy, myocarditis, etc., the false positive rate drops to zero. In other words, if you have a positive exercise test, the likelihood of not having heart disease is next to zero. The likelihood of having specific coronary disease is about 85%. When one considers the pericardities of operation, manipulation of the heart and the various operative effects, I'm not at all surprised at this positive test.

So, therefore, in terms of pain relief, it's clearly good. The question is: how do you define intractable? There are physicians who will not accept that a patient requires surgery or accept intractable pain until the man is literally dead. I find it somewhat difficult to deal with the absolute terminology of intractability. I would suggest that a number of variables have to be taken

into account. These include the patient's life-style, his age, his acceptance of surgery and his vascular anatomy.

For argument sake, consider a 49-year-old man with a perfectly good anatomical set-up for the operation. He might be a laborer or an executive who is under a lot of stress and simply finds it unreasonable to be gobbling pills, which I consider a perfectly acceptable reason for surgery. If on the other hand, he tells me, "It doesn't bother me, I will take one nitroglycerin every hour and I'm perfectly happy to do so," I have accomplished the same thing in terms of symptomatic relief. The number of pills is not a reasonable cut-off. You cannot say that a patient who takes more than 10 pills a day must have surgery; less than 10 pills, surgery is not indicated. I think the goal of medical therapy is to make the patient very comfortable, and we can frequently do that. If the means to that end requires an unacceptable, constant reliance on drugs, etc., then the patient is certainly a candidate for surgery. This is where the art of medicine comes in. It's no longer the science.

Second Major Issue

The prolongation of life issue is more difficult. The mortality rate for patients with coronary artery disease who have been treated medically has improved markedly in the past 15 years. Therefore, any study of surgical therapy must consider this change in medical treatment. While a new form of surgical therapy has been introduced, medical therapy has also become more effective in the aggressive treatment of arrhythmias and concepts of pre- and postcoronary care. Therefore, the medical therapy of patients with coronary disease is changing also.

Concerning the VA study, I agree that it was weak. In addition, the quality of the angiograms was poor. Some angiographers refused to review them. Coronary angiography in 1978 is far superior to what it was in 1971. Also, there is no question that surgical mortality is related to time and experience of the surgical team with the operation. We now have better techniques for protection of the left ventricle during surgery. For example, until three or four years ago, the preparation for surgery included withdrawal of propranolol because most cardiologists feared a decompensated ventricle at the time of surgery. Now we are not discontinuing propranolol and the rate of intraoperative myocardial infarction is decreasing.

Some Support Samples

There is a definite implication that coronary artery bypass is prolonging life. The examples that I give are the following:

A 39-year-old man with proximal vessel disease in all three vessels, almost complete obstruction lesions in the right, left anterior descending, and circumflex, with no collaterals. It is reasonable to suggest surgery for him. It is extremely likely that this man will have an infarction at some time in the next ten years. He is certainly no worse off with the operation and the grafts seem to be remaining patent for a considerable period of time.

Conversely, a 75-year-old man who has one proximal lesion, whose primary disease is distal and who has adequate collaterals, is not a candidate for operation.

I wish that I had some data to support our conviction about the management of patients who fall in groups between these two examples, but I am unaware of such information. From available information, the younger the patient, the more proximal the lesions, the less the involvement of the distal circulation, the fewer collaterals, the more I favor operating to prolong life. Data is not available to support this attitude and I don't believe we are going to get it. We are unable to establish studies that randomize people to having no therapy.

Another aspect of the VA study that should be said is that the quality of surgery was not good. Three or four hospitals contributed most of the mortality. Results of surgery at Hines and Stanford VA Hospitals were good. But when you have 25% of the hospitals responsible for 85% of the surgery and almost none of the mortality and then another 25% of the hospitals are responsible for less than 10% of the surgery, but 95% of the mortality in the total study group, it is difficult to accept the conclusions in such a study.

Medical therapy is not without its problems. Exercise mills are being created around the country for the treatment of coronary disease although there is no convincing data that exercise has any role in the secondary prevention of coronary disease. Nothing has ever been published that shows that exercising in a patient who has coronary disease will prevent or retard disease progression. However, if you question a hundred people in an exercise program after an infarct, they are quite convinced they are getting specific therapy. I find this just as reprehensible as by-

pass surgery for single vessel disease of the right coronary in patients who are asymptomatic.

We are in a quandry. The treatment of an angina is not clearly defined. One has to take the best data that is available and then make a value judgment. When we recommend surgery, I tell patients that this is my best judgment. That's the best I can do.

Dr. John Sanders: I would like to show, for the purpose of comparison, results from other series. The first study is from Houston, Texas, where the quality over the years has been excellent. The Baylor College series follows a span of over 1,000 patients, all of whom have been followed beyond five years. It has the advantage of being a year or two years longer in follow-up than the VA study. Of these, there was a virtual equal mix of two and three vessel coronary disease. The balance of these are single vessel and greater than three vessel coronary disease. Their operative mortality from a group operated on in the early seventies was still 3.5%. Now, this would be somewhat improved. Their overall five-year survival was 90%, which was better than the shorter term follow-up of the VA group. Their five-year survival in patients who have good left ventricular function was even better—93%.

The patency rates in the Baylor College study were done at between six months and a year. There was an 87% overall patency rate, that is to say, 87% of all grafts performed were patent versus 69% of the VA series. That constitutes nearly a 20% difference in patency rate. Eighty-one percent had all grafts patent versus 54% in the VA group.

The follow-up from the Brigham series was just shy of six years. The results at that time showed that for single vessel bypass we expect 97.8% survival. It does exclude suicide, auto accidents, cancer deaths and deaths not related to coronary artery disease. From the coronary standpoint we can say that we have a 97.8% survival of single vessel disease for patients 5.5 years after operation. I think that even a good medical group would certainly not fare statistically significantly better than this.

Patients who have had coronary bypass surgery for three vessel disease anticipate a better than 90% survival rate at five and six years. The overall survival for all patients bypassed in this series, which comprises almost 600 patients, was better than 90% at six years. This was comparable to the Baylor series. We now consider the

operative mortality for elective coronary surgery somewhere between 1 and 2%, which is quite acceptable for any major operative procedure. ◀

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Internal Medicine

THE HOLISTIC APPROACH IN THE CARE OF THE INDIVIDUAL WITH MALIGNANCY

For: Physicians, residents, interns. 1-hour lecture, August 23, 11:00 a.m.-12:00 noon (lunch follows), Auditorium, Martha Washington Hospital 4055 N. Western, Chicago, IL. Speaker: John Louis, M.D., Professor of Medicine, University of Health Sciences, Chicago Medical School. Reg. deadline: 8/22. Reg. limit: none. Fee: none. CME Credit: AAFP Elective, 1 hour; AMA Category 1, 1 hour. Sponsor: Medical Staff of Martha Washington Hospital. Contact: Fernando Villa, M.D. Phone: 312-583-9000 x 331.

Orthopaedics

SPECIALTY REVIEW IN ORTHOPAEDICS

For: Orthopaedists. 7 day lecture, August 13-19, Chicago, IL. Speaker: Peter C. Altner, M.D. CME credit: AAFP Elective, 64 hours; AMA Category 1, 64 hours. Fee: \$275. Reg. limit: 350. Sponsor: Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. Contact: Robert J. Baker, M.D., Dean. Phone: 312-733-2800.

Physical Medicine & Rehabilitation

ELECTROMYOGRAPHY & CLINICAL NEUROPHYSIOLOGY

For: Physiatrists & interested Physicians. 3-day course, August 16-18, Chicago, IL. CME credit: AMA Category 1, 21 hours. Reg. limit: 40. Fee: \$175, physicians; \$90, residents. Sponsor: Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago, IL 60611. Co-Sponsor: American Academy of Physical Medicine & Rehabilitation. Contact: Victoria Severson, AAPM&R. Telephone: 312-236-9512.

SEPTEMBER

Cancer

FIFTH ANNUAL CHICAGO SYMPOSIUM "CANCER IMMUNOLOGY: EXPERIMENTAL AND CLINICAL"

For: Oncologists, Surgeons, Internists, Hematologists. 3-day symposium, September 13-15, Pick-Congress Hotel, Chicago. Speaker: George Mathe, M.D., Director, Institute of Cancerologie Et D'immunogenetique, Paris. CME credit: AMA Category 1, 16 hours. Reg. deadline: 9/1. Reg. limit: 200. Fee: \$70. Sponsor: ITR-Biomedical Research of the University of Illinois 115 So. Sangamon St., Chicago, IL. Co-Sponsors: Illinois Cancer Council, American Cancer Society. Contact: Nancy Piekarski. Telephone: 312-996-4688.

Clinical Laboratory Correlation

For: Physicians. Lecture/Discussion, Sept. '78-June '79, (Thursdays, bi-weekly), Mattoon, IL. CME credit: AMA Category 1. Fee: none. Reg. limit: none. Sponsor: Sarah Bush Lincoln Health Center, R.R. 16, Box 372, Mattoon, IL 61938. Contact: Byron Ruskin, M.D. Telephone: 217-258-2514.

Hypnosis

WORKSHOP ON CLINICAL HYPNOSIS

For: Physicians, Dentists, Psychologists. 4-day workshop, September 14-17, Chicago, IL. CME credit: AMA Category 1, 25 hours; Academy of General Dentistry, 25 hours. Fee: \$225. Reg. limit: none. Sponsor: American Society of Clinical Hypnosis—Education and Research Foundation, 2400 E. Devon Ave., Suite 218, Des Plaines, IL 60018. Contact: William F. Hoffman, Jr. Telephone: 312-297-3317.

Infectious Disease/Urology

21ST MEDICAL/SURGICAL SEMINAR FOR LAKE COUNTY

For: M.D.'s, D.D.S.'s, R.N.'s, Rh.P.'s Seminar, September 20, 8:00 AM-1:00 PM, Waukegan, IL. CME credit: AAFP Elective, 5 hours; AMA Category 1, 5 hours. Reg. deadline: 9/20. Reg. limit: none. Fee: \$2.50, staff; \$5.00, non-staff. Sponsor: St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. Contact: R. M. Adelman. Telephone: 312-688-5800.

Internal Medicine

CARDIAC EMERGENCY

For: all Physicians. Symposium, September 26, Vandalia, IL. CME credit: AAFP Elective, 3 hours; AMA Category 1, 3 hours. Reg. limit: none. Sponsor: Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. Contact: Lorrain Stephenson. Telephone: 217-782-7711.

Internal Medicine

IMMUNOLOGY AND IMMUNODEFICIENCIES DISORDERS

For: all Physicians. Symposium, September 7, Quincy, IL. CME credit: AAFP Elective, 4 hours; AMA Category 1, 4 hours. Reg. limit: none. Sponsor: Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. Contact: Lorrain Stephenson. Telephone: 217-782-7711.

Internal Medicine

MANAGEMENT OF OFFICE UROLOGICAL PROBLEMS

For: all Physicians. Symposium, September 14, Carmel, IL. CME credit: AAFP Elective, 4 hours; AMA Category 1, 4 hours. Reg. limit: none. Sponsor: Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. Contact: Lorraine Stephenson. Telephone: 217-782-7711.

Internal Medicine

UPDATE ON CLINICAL IMMUNOLOGY SYMPOSIUM (RESCHEDULED)

For all Physicians. Symposium, September 7, Carbondale, IL. CME credit: AAFP Elective, 4 hours; AMA Category 1, 4 hours. Reg. limit: none. Sponsor: Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. Contact: Lorrain Stephenson. Telephone: 217-782-7711.

Internal Medicine

PERSPECTIVES IN CHRONIC MEDICINE

For: M.D.'s. 4-day course, September 20-23, Chicago, IL. Sponsor: American College of Physicians, 421 Pine St., Philadelphia, PA 19104. Co-sponsor: Northwestern University Medical School. CME Credit: AMA Category 1, 24 hours. Reg. limit: 80. Fee: ACP member/FACP/residents, \$216; ACP Associate, \$10 nonmember, \$288. Contact: Linda Salsinger. Phone: 215-243-1200.

Medicine

A STEP-BY-STEP APPROACH IN THE DIAGNOSIS OF ANEMIA

For: Physicians, residents, interns. Lecture, September 20, 11:00 a.m.-12:00 noon (lunch follows), Auditorium, Martha Washington Hospital, 4055 N. Western, Chicago, IL. Speaker: John Louis, M.D., Professor of Medicine, University of Health Sciences Chicago Medical School. CME Credit: AAFP Elective, 1 hour; AMA Category 1, 1 hour. Fee: none. Reg. limit: none. Reg. deadline: 9/19. Sponsor: Medical Staff of Martha Washington Hospital. Contact: Fernando Villa, M.D. Phone: 312-583-9000 x 331.

Medicine, Surgery

INTRAVENOUS HYPERALIMENTATION & DISEASE

For: all interested Physicians. Lecture, September 19, 7:45 p.m., Chicago, IL. Speaker: Stanley J. Dudrick, M.D., Professor & Chairman, Dept. of Surgery, University of Texas Medical School, Houston. CME credit: AMA Category 1, 2 hours. Reg. deadline: none. Fee: none. Sponsor: Louis A. Weiss Memorial Hospital 4646 No. Marine Dr., Chicago, IL 60640. Co-Sponsor: Alfred A. Strauss Memorial Lecture. Contact: Barry Millman. Telephone: 312-878-8700 x 304.

Occupational Medicine

FALL SEMINAR

For: Physicians, Nurses, Hygienists. 1½-day seminar, September 8-9, East Moline, IL. CME Credit: AAFP Elective, 8 hours; AMA Category 1, 8 hours. Fee: \$30. Reg. limit: none. Sponsor: Central States Occupational Medical Assn., 119 Shabbona Drive, Par Forest, IL 60466. Contact: Rita Packer. Phone: 312-747-8124.

Ophthalmology

DIABETIC RETINOPATHY SYMPOSIUM, PRACTICAL ASPECTS

For: M.D.'s, residents. 1-day symposium, September 9, 8:00 a.m.-5:00 p.m., Chicago, IL. **Speaker:** Felipe U. Huamonte, M.D. **Sponsor:** University of Illinois Eye & Ear Infirmary, 1855 W. Taylor, Chicago, IL 60612. **CME Credit:** AMA Category 1. **Fee:** \$100. **Reg. limit:** none. **Contact:** Dawn Fischer. **Phone:** 312-96-8023.

Ophthalmology

SEMI-ANNUAL COURSE FOR ANTERIOR AND POSTERIOR SEGMENT VITRECTOMY

For: Ophthalmologists. 2-day course, September 22-23, University of Illinois Eye & Ear Infirmary, Chicago, IL. **CME credit:** AMA Category 1, 16 hours. **Reg. limit:** 15. **Fee:** \$250. **Sponsor:** Dept. of Ophthalmology, University of Illinois, 1855 W. Taylor, Chicago, IL 60612. **Contact:** Carmen Carrasco. **Telephone:** 312-996-8024.

Orthopedics

BACK INJURIES & BACK PAIN RELATED TO SPORTS INJURIES

For: All Physicians. Symposium, September 13, Wood River, IL. **Reg. limit:** none. **CME credit:** AMA Category 1, 4 hours; AAFP Elective, 4 hours. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Contact:** Lorraine Stephenson. **Telephone:** 217-782-7711.

Pediatrics

PEDIATRIC REVIEW

For: all Physicians. Symposium, September 28, Sparta, IL. **CME credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Reg. limit:** none. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Contact:** Lorraine Stephenson. **Telephone:** 217-782-7711.

Pediatrics

SECOND ANNUAL SYMPOSIUM ON MEDICAL GENETICS

For: all Physicians. 1-day symposium, September 15, Springfield, IL. **CME credit:** AAFP Elective, 7 hours; AMA Category 1, 7 hours. **Reg. limit:** none. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Contact:** Lorraine Stephenson. **Telephone:** 217-782-7711.

Pediatrics/Obstetrics

CLEFT CONCEPT MULTI-DISCIPLINARY CONCEPT TREATMENT AND MANAGEMENT OF THE CLEFT LIP/PALATE PATIENT

For: Obstetricians, Pediatricians. 1-day symposium, September 20, 9:00 a.m.-4:00 p.m., Chicago, IL. **CME Credit:** AMA Category 1, 6 hours. **Fee:** \$35. **Reg. deadline:** 9/10. **Contact:** Eugene V. Tanski, M.D., 845 N. Michigan, Suite 925W, Chicago, IL 60611. **Phone:** 312-642-4619.

Physical Medicine & Rehabilitation

THIRD ANNUAL COURSE ON MANAGEMENT OF THE SPINAL CORD INJURED PATIENT

For: Physicians & professionals in acute spinal cord management. 5-day course, September 11-15, Chicago, IL. **CME credit:** AMA Category 1, 32 hours. **Fee:** \$200, physicians; \$125, residents. **Reg. limit:** 115. **Sponsor:** Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago, IL 60611. **Co-Sponsor:** American Academy of Physical Medicine and Rehabilitation. **Contact:** Victoria Severson, AAPM&R, 30 No. Michigan, Chicago, IL 60611. **Telephone:** 312-236-9512.

Physical Medicine & Rehabilitation

PERSPECTIVES IN CHRONIC MEDICINE

For: Physiatrists & Family Physicians. 4-day course, September 20-23, Chicago, IL. **Reg. deadline:** 8/31. **CME credit:** AMA Category 1, 20 hours. **Reg. limit:** 80. **Fee:** \$200, physicians; \$150, residents, nurses, allied health personnel. **Sponsor:** Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago, IL 60611. **Co-Sponsors:** American Academy of Physical Medicine & Rehabilitation, American College of Physicians, Northwestern University Medical School. **Contact:** Victoria Severson, AAPM&R, 30 No. Michigan, Chicago, IL 60611. **Telephone:** 312-236-9512.

VISITING PROFESSOR PROGRAM

For: Physicians, students, residents. Lecture, Sept. '78-May '79 (2nd Wednesday/mo.), 9:00 AM-4:00PM, VA Hospital, The Chicago Medical School, North Chicago, IL. **CME credit:** AMA Category 1, 5 hours (ea. session). **Reg. limit:** none. **Reg. deadline:** none. **Fee:** none. **Sponsor:** Dept. of Surgery, UHS/CMS, VA Hospital, North Chicago, IL 60064. **Contact:** Karen Jonasson. **Telephone:** 312-473-9200 x 202.

Surgery

PRE-OPERATIVE CARE OF THE SURGICAL PATIENT

For: all Physicians. Symposium, September 21, East St. Louis, IL. **CME credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Reg. limit:** none. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Contact:** Lorraine Stephenson. **Telephone:** 217-782-7711.

Surgery

INTRAVENOUS ALIMENTATION AND DISEASE

For: Physicians. 1-hour lecture, September 19, 7:30 p.m., Wallach Auditorium, Weiss Memorial Hospital, 4646 N. Marine Dr., Chicago, IL 60640. **Speaker:** Stanley J. Dudrick, M.D., Professor and Chairman of Surgery, University of Texas Medical School, Houston. **CME Credit:** AMA Category 1. **Fee:** none. **Reg. deadline:** none. **Sponsor:** Louis A. Weiss Memorial Hospital. **Co-sponsor:** Dept. of Surgery, University of Illinois. **Contact:** Anita Robins. **Phone:** 312-878-8700 x 455.

Surgery, Family/General Practice, Emergency Medicine

COMMON PROBLEMS IN HAND INJURIES

For: Practicing Physicians/Surgeons. 1-day symposium, September 23, 8:30 a.m.-5:00 p.m., St. Louis, MO. **Sponsor:** Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **CME Credit:** AAFP Elective, 6.5 hours; AMA Category 1, 6.5 hours. **Fee:** \$60. **Reg. limit:** 150. **Contact:** Loretta Giacometto. **Phone:** 314-454-3873.

Thoracic Diseases and Internal Medicine

SCREENING PROGRAMS IN EARLY DIAGNOSIS OF LUNG CANCER

For: Physicians, residents. Lecture, September 6, Auditorium, Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL 60618. **Speaker:** David R. Sanderson, M.D., Mayo Medical School, Rochester, MN. **CME credit:** AAFP Elective, 1 hour; AMA Category 1, 1 hour. **Reg. limit:** none. **Fee:** none. **Sponsor:** Martha Washington Hospital Medical Staff. **Contact:** Fernando Villa, M.D. **Telephone:** 312-583-9000 x 331.

OCTOBER

Biomed

FOURTH ANNUAL MEDICAL PHOTOGRAPHY WORKSHOP

For: all physicians. 1-day symposium/workshop, October 28, Springfield, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **CME Credit:** AAFP Elective, 6 hours; AMA Category 1, 6 hours. **Reg. limit:** none. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Diabetes

RECENT ADVANCES IN DIABETES

For: residents and attending staff. Lecture, October 25, 11:00 a.m. (lunch follows), Martha Washington Hospital, 4055 N. Western, Chicago, IL 60618. **Speaker:** Arthur H. Rubenstein, M.D., Professor and Associate Chairman, Dept. of Medicine, The University of Chicago. **CME Credit:** AAFP Elective, 1 hour; AMA Category 1, 1 hour. **Fee:** none. **Reg. limit:** none. **Reg. deadline:** 10/24. **Sponsor:** Martha Washington Hospital. **Contact:** Fernando Villa, M.D. **Phone:** 312-583-9000 x 331.

Hypnosis

ANNUAL WORKSHOP ON CLINICAL HYPNOSIS

For: Physicians, Dentists, Psychologists. 3-day workshop, October 9-11, St. Louis, MO. **Sponsor:** American Society of Clinical Hypnosis, 2400 E. Devon, Suite 218, Des Plaines, IL 60018. **CME Credit:** AMA Category 1, 24 hours. **Fee:** \$225. **Reg. limit:** none. **Co-sponsor:** American Society of Clinical Hypnosis—Education and Research Foundation. **Contact:** William Hoffman, Jr. **Phone:** 312-297-3317.

Internal Medicine

DIABETES MELITUS

For: all Physicians. Symposium, October 5, Mt. Vernon, IL. **CME Credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Reg. limit:** none. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Internal Medicine, Family Practice, Pediatrics

CLINICAL ALLERGY FOR PRACTICING PHYSICIANS

For: Physicians. 3-day symposium, October 5-7, St. Louis, MO. **Sponsor:** Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **CME Credit:** AAFP Elective, 16 hours; AMA Category 1, 16 hours; AOA, 16 hours. **Fee:** \$150. **Reg. limit:** 150. **Contact:** Loretta Giacometto. **Phone:** 314-454-3873.

Medicine and Surgery

MEDICAL AND SURGICAL APPROACHES TO ACUTE COLON AND RECTAL DISEASES

For: Physicians. Symposium, October 26, Hillsboro, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **CME Credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Reg. limit:** none. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Neurology

NEUROLOGY UPDATE

For: Physicians. Symposium, October 7, Pittsfield, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **CME Credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Reg. limit:** none. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Neurology

CLINICAL NEUROLOGY

For: Otolologists, Neurologists. 4-day course, October 16-19, Chicago, IL. **Speaker:** Nicholas Torok, M.D. **Sponsor:** Dept. of Otolaryngology, ALS.M., Illinois Eye & Ear Infirmary, Neurology Section, 1855 W. Taylor, Chicago, IL 60612. **Co-sponsor:** American Neurology Society. **CME Credit:** AMA Category 1, 28 hours. **Fee:** \$300. **Contact:** Nicholas Torok, M.D. **Phone:** 312-996-6517.

Psychiatry

ILLINOIS PSYCHIATRIC SOCIETY 5th ANNUAL FALL WEEKEND MEETING

For: Psychiatrists, other physicians. 3-day lecture/workshop, October 6-8, Hyatt Regency O'Hare, Chicago, IL. **Sponsor:** Illinois Psychiatric Society, 55 E. Monroe, Suite 3510, Chicago, IL 60603. **CME Credit:** AMA Category 1, 13.5 hours. **Fee:** \$35. **Reg. limit:** none. **Reg. deadline:** 9/25. **Contact:** Wendy Smith. **Phone:** 312-782-1654.

Surgery

CLINICAL CONGRESS

For: Physicians. 5-day lecture, October 16-20, San Francisco, CA. **Sponsor:** American College of Surgeons, 55 E. Erie, Chicago, IL 60611. **CME Credit:** AMA Category 1. **Contact:** Ginny Clark. **Phone:** 312-664-4050.

RECENT CME ACCREDITATION RECOMMENDATIONS

The ISMS Committee on CME Accreditation has recently recommended to LCCME approval of the CME programs of the following institutions:

Alexian Brothers Medical Center
Elk Grove Village
Central DuPage Hospital
Winfield
Chicago Pediatric Society
Community Memorial General Hospital
LaGrange
Cook County Hospital
Chicago
DuPage County Medical Society
Lombard
Henrotin Hospital
Chicago
Institute for Psychoanalysis
Chicago
Rockford Memorial Hospital
Roosevelt Memorial Hospital
Chicago

CLASSIFIED ADVERTISING

POSITIONS & PRACTICE OPPORTUNITIES

FULL TIME PHYSICIAN for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

OPPORTUNITIES FOR PHYSICIANS IN INDIANA—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

ACADEMIC DIRECTOR, INTERNAL MEDICINE: University of Illinois affiliated community hospital seeks individual to be responsible for undergraduate, graduate and continuing medical education, and administration of residency and outpatient center. Physician we seek must be American Board of Internal Medicine certified. In return we offer a challenging and rewarding experience plus a competitive salary and benefit program. Send resume in complete confidence to: Box 917, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

WANTED: INDUSTRIAL PHYSICIAN: Unusual opportunity for Illinois licensed physician. Full time industrial work with minor traumatic surgery and physical examinations. Regular hours. Advancement for right person. Starting salary negotiable. Write to Box 920, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

PHYSICIAN WANTED: Family Practitioner, Board Eligible or Certified, full time position. Chicago suburban group with complete diagnostic facilities. Excellent starting compensation. Profit sharing and pension program. Pleasant working conditions. Capable interested medical associates. Convenient location, regular hours, good hospital affiliation, vacations. Insurance benefits include life, hospitalization, catastrophic medical expense, disability and malpractice. Medical Society and hospital dues paid by corporation. Call collect: Eugene J. Scherba, M.D., or Administrator, Thomsen Clinic, Ltd. (312) 849-2400.

ORTHOPEDIC SURGEON who desires to locate in a rural area of southern Illinois needed to serve two community hospitals. One hour from St. Louis. Good educational system for children. Excellent recreation. Reply: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263.

WANTED—M.D., certified Family Practice, to direct and establish Family Practice Residency. Please reply to Box 927, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

ENT SPECIALIST needed in a large, fast growing Chicago suburb. No other ENT specialist in town. Very favorable terms. Send resume to Box 926, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

DERMATOLOGIST needed for a large, fast growing Chicago suburb. Solo practice. Ideal for a second office. Office space available in a new medical complex. Very favorable terms. Send resume to Box 928, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

OVERHEAD MOUNTING? WORKING LONG HOURS? Consider working in a University Health Service. 40 hour week—positive fringe benefits including generous vacation times. Illinois license. Equal opportunity/affirmative action employer. Contact: M. M. Torray, M.D., Illinois State University, Normal, Illinois 61761. Tel.: 309-438-8655.

PHYSICIAN WANTED: Internist, board certified, full time to join Chicago suburban group with complete diagnostic facilities. Excellent starting compensation, profit sharing and pension program. Pleasant working conditions. Capable, interested medical associates. Convenient location, regular hours and good hospital affiliations, vacations. Insurance benefits include Life, Hospitalization, Catastrophic Medical Expense, Disability for Illness and Accident and Malpractice. Medical society and hospital dues paid by corporation. Call collect: Eugene J. Scherba, M.D. or Administrator, Thomsen Clinic, Ltd. (312) 849-2400.

MATTOON—CHARLESTON, ILLINOIS. Sara Bush Lincoln Health Center Emergency Department has July opening for qualified physician. Guarantee \$50,000-\$55,000 with ideal working conditions and schedule. Send curriculum vitae to Stephen Allin, M.D., Emergency Department Director, P.O. Box 372, Mattoon, Illinois 61938 or call toll free 1-800-325-3982 for details.

EMERGENCY DEPARTMENT PHYSICIAN: Become part of an expanding, dynamic multispecialty clinic in midwest university community of 100,000. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801, (217) 337-3239.

GYNECOLOGIST NEEDED for new fully operational multi-specialty clinic in Libertyville. For information call 312-362-9097.

FAMILY PRACTITIONER—To associate with one senior general practitioner and one surgeon in rural southern Illinois. Excellent educational system and recreation. Financially sound community. One hour from St. Louis. JCAH 72-bed hospital in Nashville. Association available now. Contact: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois, (618) 327-8236.

PHYSICIAN WITH EMPATHY TOWARD COLLEGE AGE population to practice general medicine in 38 bed accredited hospital with large outpatient clinic. Salary negotiable. Excellent fringe benefits. Contact L. W. Combs, M.D., Director, Purdue University Student Hospital, West Lafayette, IN 47907, (317) 749-2441. Equal access/equal opportunity employer.

FOR SALE, LEASE OR RENT

MEDICAL OFFICE SUITE FOR RENT, Lincoln-Belmont Bldg. 715-1200 square feet, available at once in full service, elevator, active professional building. Call Gary Solomon, (312) 334-5400.

MEDICAL CENTER FOR RENT. Complete and ready to open. 4300 sq. ft. at 2301 E. 95th Street, Chicago. Large waiting rm., 18 exam rms., x-ray rm., central a/c & heat. Call Gary Solomon, (312) 334-5400.

SUITE TO LEASE for Internist, Pediatrician, Psychologist, Psychiatrist or other medical practice. Suite is located in a high quality building with a growing medical community situated across from a major hospital. The complex already includes an outstanding lab, X-ray facility, pharmacy and 16 professionals. Arrangement provides flexibility for the new tenant to share a suite with an existing practice, to have office built in newly created bare space and to participate in the ownership and direction of the complex. **STRONG** Property Managers, Ltd. Agents, 201 W. Springfield, Champaign, IL 61820. (217) 356-2617.

SPACIOUS Northside Lakeview area medical office for rent. Newly remodeled. Five examining rooms, carpeted. Large furnished waiting room. Available now. Interested in Spanish speaking doctors only. Growing Spanish speaking area. Near Ashland-Lincoln and Belmont. Pharmacy space also available, if desired. Please contact: Dr. Pedro O. Cabrera (Dentist) at 1442 W. Belmont or call (312) 528-0068.

FOR SALE: 31-year-old established general practice and clinic. Fully equipped and furnished. Clinic and practice can accommodate two doctors. Contact: Bob Billa, 2931 East Southcross Blvd., San Antonio, Texas 78212.

LISLE-MEDICAL SUITE available in prestigious modern building located on Rt. 53 in Lisle. X-ray facilities on premises. Zone controlled heating and air conditioning. Ample parking. Call 969-2850.

SITUATIONS WANTED

DIAGNOSTIC RADIOLOGY—Board eligible. Well trained in ultrasound, CAT scan. Part or full time. Also for film reading. Call (312) 771-8076.

DR. P. J. REDDY—Male, 39 years—Psychiatry, M.D., D.P.M., F.R.C.P.(C), ABPN, with total ten years of wide experience in Psychiatry with Illinois license looking for place in private practice or a salaried job.

DR. P. V. REDDY—Female, 34 years—OB-GYN, M.D., M.R.C.O.G. (U.K.), American Board Certified with Illinois license. Total ten years in OB-GYN. Looking for place in private practice or a salaried job. Please contact Dr. P. J. Reddy, Union Hospital, Moose Jaw, Saskatchewan, Canada. Office—(306) 692-1841; Home—(306) 693-3288.

BOARD CERTIFIED RADIOLOGIST, 40, graduate of American medical school available for film reading in office, clinic or home. Daily pick-up service if desired. Excellent references. Please contact Illinois Medical Journal, Box No. 930, 55 East Monroe, Chicago, Illinois 60603.

GUARANTY FUND CERTIFICATE

GUARANTY FUND CERTIFICATE issued by the Illinois State Medical Inter-Insurance Exchange for sale. Coverage \$100,000/\$300,000. Class 5, Specialty: Otorhinolaryngology. Original purchase price \$6,840.00. Interested: Contact Olawale O. Idewu, M.D. 9204 South Commercial Avenue, Chicago, Illinois 60617; Tel. (312) 735-8033 or 734-4243.

GUARANTY FUND CERTIFICATE: Class 4, Territory I for \$1 Million/\$1 Million. Moving out of state. Purchase price \$2572 in 1976. Please reply to Box 921, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

ISMIE GUARANTY FUND CERTIFICATE: Price (original) \$6024.00. Specialty: OB-GYN, Class V, Territory II. Have moved out of Illinois. Discount price. Will be available, Thomas T.H. Lin, M.D. 175 N. Jackson Ave., Suite 208, San Jose, CA 95116, (408) 251-5205.

GUARANTY FUND CERTIFICATE: Class 8 Inter-Insurance Exchange Certificate for sale (previously class 5). Call 266-1977, 9-5 P.M.

ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE Guaranty Fund Certificate #1160 Territory II Class 5 (1 mil/1 mil) OB-GYN for sale. Orig. price \$6024. Best offer. Left state. Contact: M. Hosseinipour, M.D., c/o P.O. Box 681, Williamson, W.Va. 25661. (606) 237-1020 or 237-1083.

GUARANTY FUND CERTIFICATE for sale at discount. Phone (312) 579-0133.

ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE Guaranty Fund Certificate for sale. Territory I Class 1—Purchase price \$772. Best offer. Please contact Mrs. Burton at 388-8052.

GUARANTY FUND CERTIFICATE issued by the Illinois State Medical Inter-Insurance Exchange for sale. Coverage \$100,000/\$300,000. Original purchase price \$6,024.00. Interested call (312) 963-8777 or 920-8792.

GUARANTY FUND CERTIFICATE—Anesthesiologist relocating, Class 5, 1,000,000/1,000,000 coverage. Original price 10,000—purchase price 8000.00 or best offer. Favorable conditions may be arranged. Send inquiries to Box 922, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

GUARANTY FUND CERTIFICATE for sale. This certificate is worth \$3096 toward your purchase of any Class III, IV or V certificate. Will discount price. Call evenings 312-293-1993.

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SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251

EKG

(Continued from page 6)

Answers: 1. A 2. E.

The ECG shows atrial flutter with 2:1 atrio-ventricular block. The atrial rate is 430 and the ventricular response is 215 beats per minute, respectively. The sharp flutter waves are seen best in the right precordial leads, notably RV_4 , or the V_4 position on the right precordium. In an older patient, the tall R waves in lead V, and RV_4 would indicate right ventricular hypertrophy. However, at this age, the R wave in RV_4 can go to 12 mm and the R wave in V_1 to 20mm. This is due to the normal right ventricular preponderance seen in the first months of life. Digitalis was given and the ventricular response slowed, but the atrial flutter did not convert to sinus rhythm. Quinidine, 15mg every six hours, was added with further control of the heart rate but without conversion to sinus rhythm. Since atrial flutter is so rare in normal hearts, it was decided to do a right heart catheterization to rule out any

left to right shunts and measure pressures in the pulmonary artery, right ventricle, right atrium, and pulmonary capillary wedge position. All pressures were normal. A small left to right shunt was found at the atrial level and was felt to be compatible with a patent foramen ovale or small atrial septal defect. Direct current cardioversion at 7 watt-seconds converted the atrial flutter to normal sinus rhythm. Maintenance digitalis and quinidine were eventually discontinued. The child has continued normally and now, at age four years, has a normal chest X-ray and ECG. This patient had a normal heart by catheter studies and in follow-up examinations. The etiology of the atrial flutter was never explained. This shows that the significance of atrial flutter is closely bound to the underlying cardiac pathology.

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Abstracts of Board Actions

(Continued from page 4)

In other PSRO-related action, ISMS will introduce a resolution at the AMA Annual Meeting—June 18-22 in St. Louis—urging AMA to seek legislation that would exempt PSROs from the Freedom of Information Act. A U.S. District Court recently declared that a Washington, D.C.-area PSRO is an "agent" of the federal government and thereby is required to disclose identified PSRO data under the Information Act. In outlining procedures to alleviate the breach of confidentiality problem, the court pointed out that the remedy lies with Congress, not the courts.

'79 Board Meeting Dates

The 1979 Board of Trustees meeting schedule is:

- Jan. 27-28 — Palmer House or Ambassador West
- Mar. 10-11 — (location not yet determined)
- May 5-9 — Palmer House (Annual Meeting of House of Delegates)
- June 14 — (one-day session devoted primarily to council & committee appointments plus emergency items)
- Sept. 15-16 — Ambassador West
- Nov. 9-11 — Holiday Inn, Decatur (Interim Session of House of Delegates)

Liaison Committee With Bar Association

ISMS and Illinois Bar Association will each name three representatives to a Liaison Committee to resolve increasing problems between physicians and lawyers. The Chicago Medical Society and Chicago Bar Association will be invited to each name two members. ISMS representatives will include: Drs. Mike Murphy, Belleville; Robert Fox, Glenview; and Donald Aaronson, Chicago.

AMA Jail Project

ISMS will be one of 10 state medical societies added to the list of participants in the AMA Program to Improve Health Care in Jails. The Society will receive a \$5,000 grant from the Law Enforcement Assistance Administration—through AMA—to set up and administer the project.

AMA Dues Billing

The Board endorsed the AMA Criteria for Dues Billing & Remittance which states:

Each society receiving AMA dues should forward AMA dues and a list of the payers of the dues within 30 days of receipt of the dues. All dues collected within the last 30 days prior to the AMA delinquency date should be forwarded in time to reach the AMA prior to that delinquency date.

By agreeing to the criteria, ISMS will be reimbursed by the AMA on the following formula basis:

- 2% of dues received by the AMA no later than January 15.
- 1.5% of dues received by AMA no later than February 15.
- 1% of dues received by AMA no later than March 15.
- .5% of dues received by AMA after March 15.

The foregoing will be shared on an equitable basis with those component societies involved in the billing process.

CME Accreditation

ISMS will seek accreditation to grant Category I credit for CME programs. This will allow the Society more freedom in programming and eliminate the need to secure co-sponsors for programs in order to offer the Category I credit. Accreditation is granted by the National Liaison Committee on Continuing Medical Education.

IDPA Drug Manual

The following drugs were approved for inclusion in the IDPA Drug Manual: Limbitrol, Depakene (Valproic Acid), Theodur, Hydergine R-Oral tablets (automatic), Ocusert, Benylin Cough Syrup (automatic), Deconamine (list to Chlorpheniramine), Decubitex (under dermatological preparations) and Metamucil (21 oz. dose available).

Designated Products

Next month, the Illinois Dangerous Drugs Commission is expected to act on proposed scheduling of Talwin into Schedule II of the Controlled Substances Act . . . and review a proposal by the Dangerous Drugs Advisory Committee to classify the drug as a "designated product."

Conference on Cost Effectiveness

The ISMS Task Force on Cost Effectiveness will sponsor a June 14 conference on health care costs. The session—a followup to a similar program last February—will be attended by representatives of labor, management, insurance, banking, local and state government. Focus of the day-long session will be the role of physicians and hospitals in cost containment.

Appointments/Nominations

Several hundred ISMS members were appointed to one-year terms on the Society's various councils and committees for 1978-79. Appointed Council chairmen were: Drs. Norman Frank, Clarendon Hills, Affiliate Societies; Michael Murray, Olney, Economics and Peer Review; Charles McHugh, Chicago, Education and Manpower; Tassos Nassos, Chicago, Governmental Affairs; Eugene Vickery, Lena, Medical-Legal; Glen Tomlinson, Lincoln, Medical Service; Arthur Traugott, Urbana, Mental Health and Addiction; and Mack Hollowell, Charleston, Public Relations and Membership Services.

Legislation

The Board voted to oppose the following pending legislation which would:

- Amend current certificate-of-need law to conform to federal provisions and extend the definition of "health care facilities" to kidney treatment centers. Local health planning agencies would be required to coordinate planning procedures with provisions of the federal Social Security Act and Public Law 93-641.
- Reduce the IDPA appropriation for medical assistance by \$54 million.
- Add to the list of grounds for suspension or revocation of a license the suspension or termination from participation in Medicaid, provided such suspension was based on gross and willful misconduct. If it appears impossible to defeat this bill, ISMS will seek to remove provisions referring to *suspension* from Medicaid as grounds for revocation of a license.

The Board voted to support pending legislation which would:

- Allow license renewal fees—currently earmarked only for the Medical Disciplinary Board—to be used for costs related to license renewal and administration of licensing requirements pertaining to continuing medical education.
- Direct Title XIX Public Aid payments for treatment in state medical facilities into the Mental Health Fund administered by IDMHDD. This would allow greater flexibility in the use of these funds to provide patient care.
- Appropriate an addition \$20 million in Fiscal '79 for Medicaid payments to physicians.

Pending a favorable review by legal counsel, ISMS will support a proposal which would allow a plea of "guilty, mitigated by mental illness," in criminal cases. The Board agreed that this proposal--embodied in HB 2755--was more acceptable than another bill which would eliminate the current plea of "not guilty by reason of insanity."

ISMS will vigorously work to amend legislation dealing with a new Mental Health Code to insure that hospital admission (including voluntary certification), treatment and discharge procedures for mental or physical illness shall be--without exception--the responsibility of a physician licensed to practice medicine in all its branches. The pending legislation allows non-medical personnel to participate in involuntary commitment procedures.

ISMS will seek to amend legislation which would permit emergency medical personnel to perform procedures without direct physician authorization when conditions prevent direct voice contact with a hospital or physician supervisor. ISMS will attempt to limit such activity to procedures specifically listed in the protocol books required for study prior to certification.

The Illinois Constitution requires abolition of the personal property tax. A proposal pending in the General Assembly would institute an income tax on corporations and partnerships as well as other entities as a method of replacing revenue lost through abolition of the property tax. ISMS will oppose the bill--HB 2418--and support an amendment calling for a two-year delay on any action to replace the property tax.

ISMS will send a delegation to Washington to meet with Illinois Senators and voice objection to SR 2410 which would extend certificate-of-need to physician offices.

Ambulatory Surgical Treatment Centers

The Board endorsed the concept of allowing Ambulatory Surgical Treatment Centers (ASTC) to maintain repositories for controlled substances provided such repositories are registered and maintained in keeping with current regulations. Presently, ASTCs may have a limited pharmacy and each physician practicing at a center may have his own supply. The Board agreed that more stringent rules are necessary and authorized the Council on Mental Health and Addiction to draft amendatory legislation if needed.

Alcoholism

ISMS will seek to amend Illinois statutes so that physicians may treat minors for alcohol intoxication without parental consent. A legislative interpretation of alcohol as a drug will be necessary to include intoxication as a form of drug abuse, thereby allowing confidential treatment.

The Board voted to encourage the IDMHDD's Division of Alcoholism to prepare a program for physicians to use in educating women as to the health risks posed to a fetus by moderate to heavy consumption of alcohol during pregnancy. The Board also directed the Council on Mental Health and Addiction to consider working with the Dangerous Drugs Commission in formulating a similar program concerning risks to the fetus posed by other drug usage during pregnancy.

ISMS will distribute to members an insert for the Physician Desk Reference explaining the interaction effect of alcoholic beverages with commonly-prescribed medications. Costs of printing and distribution will be covered by an educational grant from the IDMHDD Division of Alcoholism.

IMPAC

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street
Chicago, Illinois 60603
312/782-1963


WHERE ARE YOUR CANDIDATES?

Fellow Physicians:

It is July, 1978. By the time you read this the spring session of the General Assembly will have ended. Incumbent legislators and newcomers alike will be home in their districts organizing for the fall election campaigns. Are you organized to help the best candidates get elected?

Across Illinois, physicians and their spouses are voluntarily and temporarily uniting to form physician candidate support committees. Physicians throughout Illinois take part in the elective process by supporting the candidates of their own preferences. Through this support, physicians influence the selection of those who ultimately decide what course government is to follow. Through active participation, physicians can effectively contribute toward assuring that there will be an open channel of communication between medicine and government when legislation is being considered that will affect the profession and the public. Remember, in today's society, politics cannot be separated from government. To have a voice in government, political activity is necessary. And in this case political activity doesn't just mean giving money. Money helps but money by itself doesn't win elections. Elections are won by votes and those votes are won by the hard work of many people. Physicians and their families must be well organized to provide the help that will elect superior candidates.

IMPAC can help you organize. For further information write: IMPAC, 55 East Monroe Street, Chicago, Illinois 60603. And do so now so that you can organize immediately to provide maximum support to the candidates of your choice.



Herbert Sohn, M.D.
Chairman

P.S. If you are not a member of IMPAC please join immediately. Only through active participation in our organization can we implement good legislation.

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

Doctor's News

LICENSES ONCE ISSUED, MUST BE RENEWED—It recently has been noted before the Medical Examining Committee of the Department of Registration and Education that some physicians may be practicing with expired licenses.

Licenses, once issued, must be renewed every two years, on the first of July, even-numbered years.

Technically, if a license is not so renewed a physician is practicing without a license. During such practice, it is conceivable that professional liability insurance, even though purchased, will not provide coverage or defense against claims.

In addition, several instances have been identified in which a physician's spouse or office personnel have renewed a deceased person's license.

License renewal is accomplished through the Medical Examining Committee, Department of Registration and Education, 628 East Adams, Springfield, Illinois 62786. If one has not received a renewal notice for July 1, 1978, please write or call immediately (217) 782-7934.

It is recommended that physicians bring this to the attention of their fellow practitioners, to their hospital staff members, and to their county medical societies. If a physician has not renewed his license since it was issued, and it was issued prior to July 1, 1976, it may very well have lapsed. Serious problems could ensue.

HOSPITAL CME OPPORTUNITY—The Ohio Medical Education Network (OMEN) has announced that memberships are available for the 1978-79 program schedule. OMEN is a telephone network for physicians, supplying CME lectures from the Ohio State University. One hour of AMA Category 1 credit is available for each of 30 weekly programs, which are broadcast at 11:00 a.m. for one hour. Ten Illinois hospitals currently hold membership in OMEN.

The programs are conducted for small group seminars, and consist of a 30 minute lecture and 30 minute discussion through a closed-circuit amplified telephone. Cost to interested hospitals is determined on a sliding scale based upon bed capacity. Visual aids and outlines are mailed to participating hospitals one week before each session. The deadline for membership application is July 26, 1978, but a limited number of late applications may be accepted. For further information on specific lectures and costs, contact: Arthur Bartfray, CCME, A-352 Starling-Loving, 320 W. 10th Ave., Columbus, Ohio 43210.

NATIONAL CONFERENCE ON THE IMPAIRED PHYSICIAN—The third AMA conference on treatment of physicians impaired due to alcoholism, drug dependence or mental illness will be held September 29-October 1 at the Sheraton Ritz Hotel in Minneapolis, Minnesota. Conference participants will attend lectures and workshops regarding programs sponsored by state medical societies, hospitals and medical boards, and participate in discussion groups on all aspects of the problem. For further information, please contact: AMA, Department of Meeting Services, 535 N. Dearborn St., Chicago, 60610, before September 8, 1978.

COST VICTORY REPORTED—Rockford Memorial Hospital has announced a reduction in its daily room rates by \$1.50 per day, for private and semi-private rooms in medical/surgical, pediatric and rehabilitation units. In announcing the decrease, spokesmen attributed the savings in comprehensive professional liability insurance premiums this year, due to favorable claims-experience.

UPCOMING MEETINGS—The World Federation of Nuclear Medicine and Biology will hold their second international congress September 17-21, in Washington, D.C. Approximately 3,000 nuclear medicine specialists from six continents are expected to attend. Further information may be obtained by writing: WFNMB Second International Congress, 1629 K Street, N.W., Suite 700, Washington, D.C. 20006.

The American Academy of Occupational Medicine and American Academy of Industrial Hygiene will hold their joint annual meeting September 19-22 in Williamsburg, Virginia. The regular scientific sessions on September 20-22 will be preceded by two postgraduate seminars on the first day of the conference. For further information contact the American Academy of Occupational Medicine, 150 N. Wacker Dr., Chicago 60606.

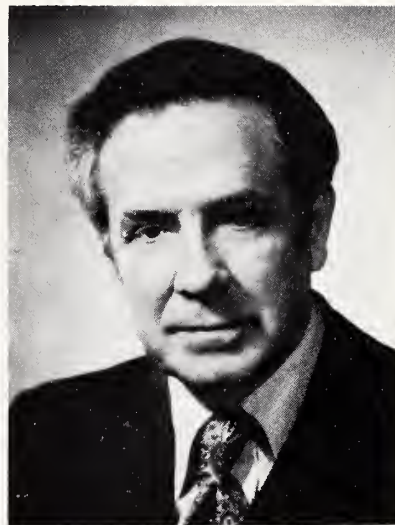
PHYSICIANS IN THE NEWS—**Silvio Aladjem, M.D.**, Chicago, is the new professor and chairman of the department of obstetrics and gynecology for Loyola University Medical Center in Maywood. . . . **Frederick D. Malkinson, M.D.**, Chicago, has been elected to serve as vice president for the Society for Investigative Dermatology. . . . The Illinois Society of Pathologists has elected new officers. **John G. Dietrich, M.D.**, Springfield, **Peter J. Soto, M.D.**, Belleville, **Marshall H. Short, M.D.**, River Forest, and **James C. Pritchard, M.D.**, Geneva, will form the new roster of officers.

Robert J. Becker, M.D., Joliet, recently received the sixth annual Clemens von Pirquet award from Georgetown University in Washington, D.C. The award recognizes work as a national lobbyist in legislation regarding the Clean Air Bill, drug reform measures and issues related to immunologic and allergic health problems. . . . The Chicago Society of Industrial Medicine and Surgery recently elected **Meredith E. Keller, M.D.**, to serve as their new president. Other new officers included **John J. Brosnan, M.D.**, vice president and **Robert S. Kassriel, M.D.**, Secretary-Treasurer.

Four Chicago plastic surgical resident physicians recently received awards for research papers presented to the Chicago Society of Plastic Surgery. First place awards were given to **William Georgis, M.D.**, and **John O. Kucan, M.D.** **Frank Madda, M.D.**, and **Raymond E. Shively, M.D.**, received second place awards for their work.

AN ERROR—COMPOUNDED—In the May Doctor's News, erroneous information was contained in the item entitled "Controlled Substance Update." The June issue unsuccessfully attempted to correct the error, but again the facts were inadvertently misstated. This is regretted and apologies are extended.

The story, based upon Dangerous Drugs Commission information, should have stated that there is a *proposal* to place Phencyclidine (PCP) and Pentazocine (Talwin) in Schedule II. Currently PCP is in Schedule III; Pentazocine is *not* scheduled on the current Controlled Substance List. This proposal has been published in the "Illinois Register" and will be acted upon by the Dangerous Drugs Commission (DDC) at its August 1, meeting. Interested parties may send comments to the DDC, 300 N. State Street, Chicago, 60610. DDC action will be reported in forthcoming issues.



Mandatory CME

This month marked the first license renewal period requiring evidence of CME credits. Although the requirement is reasonable, it has been sharply criticized by some physicians. Perhaps the criticism reflected an "off-the-cuff" reaction rather than thoughtful consideration of the details or the alternative.

The alternative was re-examination. In this age of public accountability, the drive to impose a re-examination requirement had gained considerable momentum before it was diffused by enactment of the CME law.

Most physicians agree that CME is needed to keep abreast of developments in their particular fields of medicine. In fact, surveys indicate that the majority of physicians voluntarily have been logging enough credits to meet the requirement. For these physicians, the Illinois law merely demands documentation of ongoing activities.

The requirement of 100 hours every two years should not prove burdensome even to those few physicians who largely have ignored CME opportunities. *It averages out to a total of less than one hour per week!*

Obviously, mandatory CME is an acceptable alternative to re-examination for relicensure. In addition, it represents a documented effort by physicians to maintain the highest possible standard of care. This enhances the profession's credibility—our most effective weapon in the fight to retain our professional freedom. ◀

A handwritten signature in dark ink, reading "David S. Fox". The signature is fluid and cursive, with a large "D" and "F".

David S. Fox, M.D., President

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

CHICAGO: Opportunities Available for Family Practitioners in a single specialty clinic setting. Association as a satellite facility with a 265 bed community hospital. Opportunity to build own practice with financial assistance available. Contact: Teryl R. Filebark, 1044 N. Francisco Ave., Chicago 60622. (312) 278-8800. (9)

CHICAGO (desirable suburb): Older general practitioner has excellent office facilities to share with younger G.P. Objective: need help with practice. Younger man may have guarantee to take over practice in near future. Hospital staff appointment available. All replies confidential. Box MK, Physician Recruitment Program, ISMS. (9)

ELGIN: Psychiatrist, $\frac{3}{4}$ time position with CMHC. Provide leadership and direction of medical and psychiatric aspects of clinical program, consult with staff, provide direct service to a wide variety of patients. Experience: past residency, preferably Board certified. Resume and salary requirements would be helpful to: Jack Crook, Director of Programs, Fox Valley Mental Health Center, 384 Division, Elgin, 60120, (312) 695-1115. (10)

FAIRBURY: Population 3,500. Rural area serving a population of more than 16,000. Excellent practice opportunity for family practitioner or internist interested in family practice. Enjoy life and your practice in an area which offers excellent facilities and a personal, friendly atmosphere; join the staff of 112-bed JCAH accredited community hospital. Write: Frank Brady, Administrator, Fairbury Hospital, Fairbury, 61739, or call collect (815) 692-2346. (10)

FORT MADISON, IOWA: Openings for 2-4 FP/GP, Ped., in growing industrial city of 16,000 serving 70,000 on Mississippi River. Solo, partnership, clinic available. Substantial salary, other incentive. U. of Ia. near, excellent living area, 125 bed accredited hospital. Contact Donald A. Buckert, Fort Madison Community Hospital, Fort Madison, Ia. 52627. (319) 372-6530. (7)

FREEPORT: Internist-general internist or internist with sub-specialty, board certified or eligible to join multi-specialty group in community of 35,000 in Northern Illinois. Excellent salary first year then partnership. Excellent retirement and fringe benefits. Send curriculum vita and references to K. H. Shons, Business Manager, Freeport Medical Clinic, Ltd., 3103 West Stephenson Road, Freeport, 61032. (815) 235-6131 (7)

HERRIN: Population 10,000. Trade area 40,000. Located in beautiful vacationland of Southern Illinois, near major university and medical school. Family Practice and OB-Gyn needed. Solo or clinic available. Excellent financial program provided. Modern well equipped

hospital. Call collect or write, Larry Feil, Herrin Hospital, Herrin, 62948—Tel. (618) 942-4710. (7)

MENDOTA: General practice, second physician for Wholistic Health Center of Mendota, Illinois. Innovative program with additional staff for counseling and patient education. Excellent local hospital. Future openings available in five other Wholistic Health Centers in the planning stage. Call or write: Lucy Young, M.D., 607 Tenth Ave., Mendota, 61342. (815) 539-3888 (7)

MINIER: General or family practitioner for rich agricultural area near Bloomington. Large practice waiting due to death of doctor. Office with X-ray and other equipment, very reasonable. Unusual opportunity. Contact: Harvey Graff, Minier 61759. (309) 392-2345 or 392-2120. (10)

OSWEGO: Family physician or internist to join group of four in a small town primary care clinic. Two full-service hospitals nearby. One hour west of Chicago. Dr. A. Haan, Oswego, 60543. (312) 554-8431. (11)

OTTAWA: Opening in fields of Internal Medicine and Family Practice with multi-specialty group of nine physicians. Community, 20,000 plus. 154 bed hospital under five years old. Latest equipment One and one-half hours from Chicago and Peoria. Near State Parks. Excellent school system. Close to Jr. College and State Universities. Salary negotiable. CONTACT: Mrs. Van Buren, Ottawa Medical Center, 313 W. Madison, Ottawa 61350. (815) 433-1010. (10)

PEORIA: Emergency physician—Unique opportunity to start on the ground floor with fee-for-service group in 550-bed medical center seeing 27,000 ER visits. Need career-minded physician for three 16-hour shifts per week with four weeks paid vacation. Compensation 57K with excellent corporate benefits plus incentive compensation. Flexible scheduling to allow individual pursuits in university town of 250,000 in Central Illinois. Contact: Hospital Emergency Physicians S.C., 221 Northeast Glen Oak, Peoria, 61636; phone 309-672-4974. (8)

UNION COUNTY: Population 17,000. Clinic and office facilities available for family practitioner and physician of internal medicine. Special Care Unit under construction in County Hospital. Nearby cities of Carbondale and Cape Girardeau 25 miles away. Recreational facilities plentiful. Contact: E. A. Helfrich, 517 N. Main, Anna, 62906 AC 618-833-5155. (7)

WAUKEGAN: Population 67,000, northern Chicago Suburb. Newly remodeled medical center near hospital. Looking for Internist, Family Physician. Contact Washington Center, 1515 Washington St., Waukegan 60085, Y. Lee, M.D. 312-336-2221 or 729-5407. (9)

A Difference in Theophylline Therapy

micro-pulverized

BRONKODYL[®] Capsules

brand of theophylline, USP anhydrous



- Blood levels as fast as an elixir
- With minimal gastric irritation*

*Please see complete prescribing information, a summary of which follows.

DESCRIPTION:

Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:

Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON

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90 Park Avenue, New York, N.Y. 10016

COLBY PROCLAIMS WOMAN SUFFRAGE

**Signs Certificate of Ratification
at His Home Without
Women Witnesses.**

MILITANTS VEXED AT PRIVACY.

**Wanted Movies of Ceremony,
But Both Factions Are**

WASHINGTON, Aug. 26, 1920—
struggle for wom-



TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

**President Hails 'Great
Instrument of Peace,'
Insists It Be Used**

HISTORIC LANDMARK

**Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain**

"If we fail to use it," he declared to the solemn final meeting of the delegates, "we shall betray all of those who have died in order that we might meet here in freedom and safety to create it."

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the

Social Security Bill Is Signed Gives Pensions to Aged, Jo

**Roosevelt Approves Message Intended to Benefit 30,
Persons When States Adopt Cooperating Laws—He
the Measure 'Cornerstone' of His Economic Prog**

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

**Amendment to Constitution
is Sent to House, Where
Passage is Expected**

WASHINGTON, March 10,
1971—The Senate approved
today, 94 to 0, and sent to

WASHINGTON, Aug.
The Social Security Bill,
a broad program of unen
insurance and old age
and counted upon to be
20,000,000 persons, beca
day when it was signed
dent Roosevelt in the p
those chiefly responsibl
ting it through Congress

Mr. Roosevelt called th
"the cornerstone in a
which is being built
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WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after re-
ceiving a report from the
Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.



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Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or

oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available.

Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypocoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.



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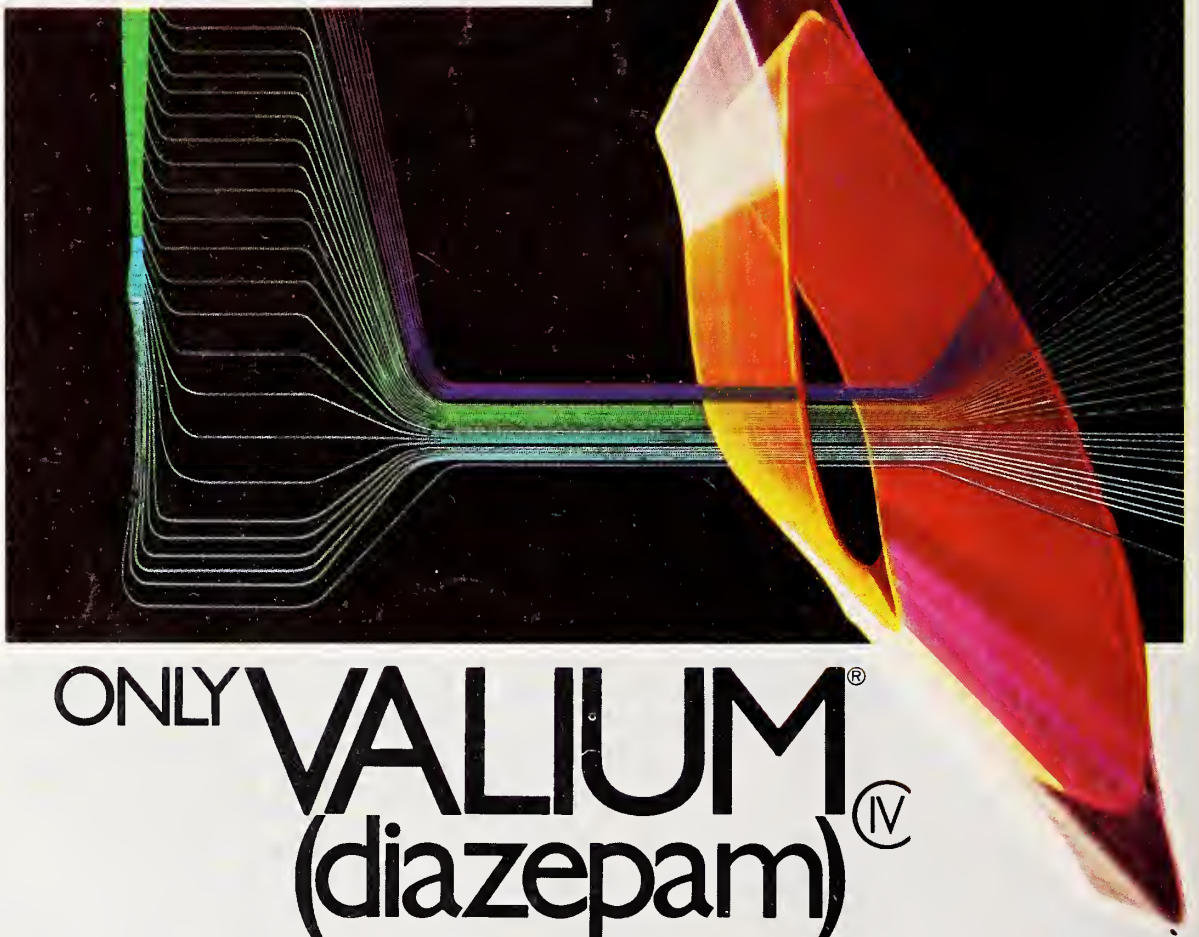
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Please see preceding page for a summary of product information.

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Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

Volume 154, No. 2, August, 1978

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IMJ series

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

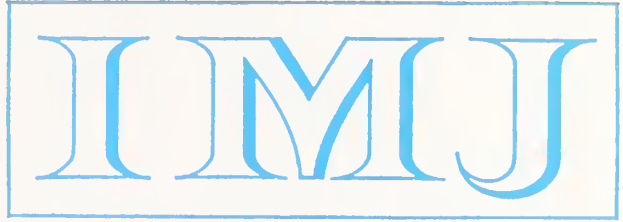
affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Clinics for Crippled Children

Thirty-six clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-five general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be nine special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

September 1 Division Cardiac—U. of I. at the Medical Center

September 5 Park Ridge Cardiac—Lutheran General Hospital

September 6 Hinsdale—Hinsdale Sanitarium

September 7 Effingham—St. Anthony's Mem. Hosp.

September 7 Sterling—Community General Hospital

September 7 Lake County Cardiac—Victory Memorial Hospital

September 8 Chicago Heights Cardiac—St. James Hosp.

September 11 Peoria Cardiac—St. Francis Hospital

September 12 Carrollton—Boyd Memorial Hospital

September 12 Peoria—St. Francis Hospital

September 12 E. St. Louis—Christian Welfare Hosp.

September 13 Carmi—Carmi Township Hospital

September 13 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults

September 13 Champaign-Urbana—McKinley Hospital

September 13 Joliet—St. Joseph's Hospital

September 13 Chicago Heights General—St. James Hosp.

September 14 Springfield—St. John's Hospital

September 15 Kankakee Cardiac—St. Mary's Hospital

September 18 Maywood—Loyola Medical Center

September 19 Anna—Union County Hospital

September 19 Rock Island—Moline Public Hospital

September 19 Decatur—Decatur Memorial Hospital

September 19 Belleville—St. Elizabeth's Hospital

September 20 Centralia—St. Mary's Hospital

September 20 Springfield Ped-Neuro—St. John's Hosp.

September 20 Evergreen Park—Little Company of Mary Hospital

September 21 Rockford—Rockford Memorial Hospital

September 21 Elmhurst Cardiac—Memorial Hospital of DuPage County

September 22 Chicago Heights Cardiac—St. James Hospital

September 25 Peoria Cardiac—St. Francis Hospital

September 26 Peoria—St. Francis Hospital

September 26 Alton—Alton Memorial Hospital

September 27 Elgin—Sherman Hospital

September 27 Chicago Heights Gen.—St. James Hospital

September 28 West Frankfort—Union Hospital

September 28 Macomb—McDonough District Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

for August, 1978

Librax®

Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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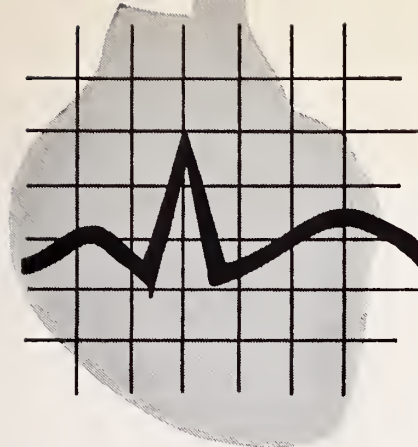
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QUARZAN[®] (clidinium Br) for adjunctive therapy
of irritable bowel syndrome* and duodenal ulcer.*



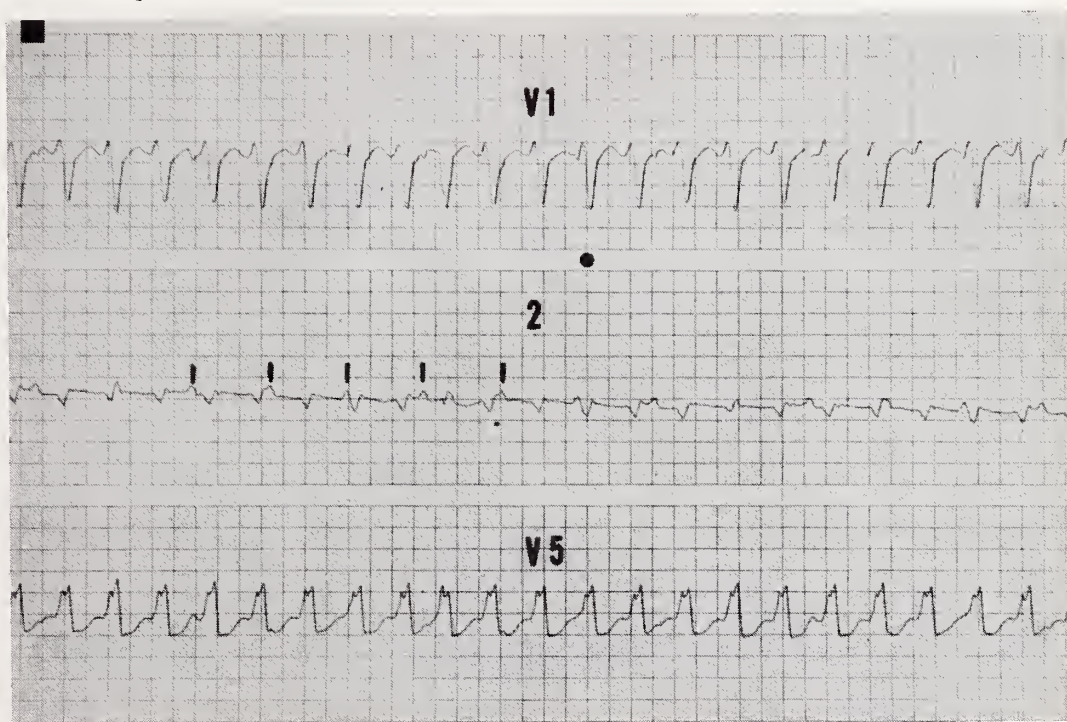
*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.



ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID L. FISHMAN, M.D.,
PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This patient is a 67-year-old man who was in good health until he sustained an acute inferior wall myocardial infarction. He made an uneventful recovery from this myocardial infarction. However, during the subsequent twelve months, he was hospitalized four times for palpitations and mild congestive heart failure. His complaints were palpitations, fatigue and some dyspnea. Each time his physical examination was significant for a normal blood pressure, a tachycardia of 140 beats per minute, a gallop rhythm and bibasilar rales on pulmonary examination. The simultaneous V_1 - V_5 rhythm strip electrocardiogram shown occurred on his most recent admission. Physical examination was the same as on earlier hospitalizations. His blood pressure was 136/86 and the tachycardia was 136 beats per minute. Cardiac catheterization was considered on this admission.



Questions:

1. The ECG shows:

- A. Atrial fibrillation with complete left bundle branch block.
- B. Complete atrioventricular dissociation.
- C. Ventricular tachycardia.
- D. Atrial tachycardia with the Wolf-Parkinson-White syndrome.
- E. Fascicular ventricular tachycardia.

2. Which of the following treatments have

been used for recurrent ventricular tachycardia?

- A. Direct current cardioversion.
- B. Intravenous lidocaine
Procainamide
Quinidine
- C. Beta adrenergic blockade (Propranolol)
Diphenylhydantoin (Dilantin), Disopyramide (Norpace)
- D. Artificial pacemakers, epicardial mapping open heart surgery.
- E. All of the above.

(Continued on page 107)

A New Vision of Catapres[®] (clonidine HCl)

20/20

The first 20 days

- Catapres lowers blood pressure promptly.
- No contraindications.
- Some patients may have dry mouth, drowsiness, and sedation. Tell them that these tend to diminish with continued use.
- Giving the larger part of the divided dose at bedtime can help alleviate drowsiness and sedation.

The next 20 years^{*}

- Lowered blood pressure.
- Little impotence, depression or postural hypotension.
- No fatal hepatotoxicity in over a decade of worldwide use.
- Broad therapeutic dosage range to keep step with changing dosage needs over the years.

^{*} Tolerance may develop in some patients, necessitating a reevaluation of therapy.

For full details on adverse reactions, warnings, and precautions, see brief summary of the prescribing information on last page of this advertisement.





Catapres[®] (clonidine HCl)
**For Step 2 in
Hypertension**



Dyazide

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Makes Sense in Hypertension*

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

*** Warning**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO.
a SmithKline company

Carolina, P.R. 00630

**Blue Cross®
Blue Shield®**



REPORT

FOR *Illinois Physicians*

Announcement on PAT Program and Ambulatory Surgery

An announcement urging the development or further implementation of two cost-effective benefit programs—Pre-Admission Testing for surgical patients (PAT) and Ambulatory Surgery when procedures are appropriate—has been mailed to hospital Administrators and Chiefs of Staff by the Illinois Blue Cross and Blue Shield Plan.

Over the co-signatures of Plan officers Richard C. Shaw, M.D., Vice President and Medical Director, and Mr. Robert S. Petersen, Senior Vice President, Provider Affairs, the announcement states:

"Two benefits pioneered by hospitals and their medical staffs and Blue Cross and Blue Shield are receiving increased attention as examples of programs that can ensure quality care while being cost effective. These programs are Pre-Admission Testing for surgical patients and Ambulatory Surgery.

"Many hospitals have such programs; unfortunately, not all; and those that are available are often not used as frequently as they could be.

"We *urge* you and your colleagues to take a new look at these programs; develop them if they do not now exist in your hospital; and see if there aren't opportunities to increase their utilization, if they do exist.

"We at Blue Cross-Blue Shield will also be looking at the programs by monitoring utilization to identify services which could have been appropriately carried out in Ambulatory Surgical settings or on a Pre-Admission Testing basis. We will review claims with you, when our monitoring indicates cases in which there may have been potential savings by utilizing one of these programs," the announcement emphasized.

As guidelines for the two programs, the announcement stated that the Medical Department has prepared a list of surgical procedures which often can be performed on an Ambulatory basis, and a similar list of elective surgical procedures for which Pre-Admission Testing is usually appropriate. Copies of the lists were enclosed with the announcement.

The announcement concluded with the statement that further information and assistance on establishing programs or expanding their utilization will be available by contacting either the Medical or Provider Affairs Department, Blue Cross and Blue Shield, 233 North Michigan Ave., Chicago, Illinois 60601.

Supplement to Medical Assistants' Handbook to Be Distributed

The Supplement to the Second Edition of Blue Shield's Medical Assistants' Handbook has been completed and single copies will be mailed to physicians' offices by the Illinois Blue Cross and Blue Shield Plan. Mailing is expected to be completed by August 31.

The Supplement was prepared by the Professional Relations Department of the Plan to serve as an interim guide for medical assistants until the Third Edition of the Handbook is published.

It contains new information on several Blue Shield topics, and revises certain information in the Medical Assistants' Handbook, Second Edition, which was distributed to medical assistants in June, 1976.

The new 50-page publication reviews instructions on the proper completion of service reports, with special attention given to the new Blue Shield

Physician's Service Report and Radiology Service Report forms. It also includes changes in reporting anesthesia services; certain changes in coverages for special groups; information on contacting our Professional Relations Representatives; Outpatient Emergency Care; and a new Directory of Blue Shield Plans.

An entire section of the Supplement illustrates the proper completion of service reports for a number of specific procedures including: surgery, services of a surgical assistant, fracture care, medical care, consultation, anesthesia, diagnostic X-ray, radiation therapy, psychiatric care, laboratory services and intensive medical care.

Explanations are given on special coverages including Supplemental Major Medical and Comprehensive Major Medical.

Changes in benefits for certain special groups are summarized, including: the Illinois Health Improvement Association; Bell Telephone; the Motor Groups; Federal Employees Program, United Mine Workers of America and State of Illinois Employees.

Medicare Home Health Coverage

Medicare covers certain services rendered to homebound patients by Medicare-certified Home Health Agencies when the services are ordered by the physician. Medicare provides for up to 100 visits per benefit period under Part A, and up to 100 visits per calendar year under Part B, when the services being rendered meet home health coverage criteria.

The services which would qualify for coverage are intermittent skilled nursing care, skilled physical therapy, and skilled speech therapy. In addition, when any of these three services are being rendered, Medicare may also cover occupational therapy, services of home health aides, medical social services, and medical supplies and equipment.

Conditions to be Met

Even though a person is entitled to Medicare, there are several conditions that must be met before home health services are covered. These are:

1. The patient must be confined to his/her home;
2. The services must be medically reasonable and necessary for the treatment of an illness or injury;
3. There must be a need for at least one skilled service; and,
4. The services must be rendered on an intermittent basis—as least once every sixty (60) days.

Part A Hospital Insurance will pay 100% of any and all home health care services, including medical supplies and the rental of equipment, providing a patient meets the three day prior qualifying hospital stay requirement, and the attending physician puts the orders and plan of treatment in writing within 14 days of discharge from the hospital.

Part B Medical Insurance will pay 100% of any and all services, including medical supplies and the rental of equipment, after the patient has met the current Part B deductible amount and providing the attending physician has the plan of treatment in writing prior to the Agency's submission of the initial Medicare claim.

Future articles will provide further details on covered home health care.

Changes in Participation and Certification of Laboratory Procedures

Notices were received from the Medicare Bureau of the following changes in participation and certification of procedures of laboratories in the Medicare program:

Relocation:

Rhodes Medical Laboratory, Inc. (Provider Number 14-8344) is now located at 1420 North Milwaukee Ave., Chicago, Illinois 60622.

Changes in Approved Specialties or Subspecialties:

LaSalle Scientific Medical Laboratory, 914 West Diversey Parkway, Chicago, Illinois 60614 (Provider Number 14-8307) is no longer approved to perform Procedure 710-EKG Services, effective August 1, 1978. The laboratory is still approved to perform Procedures 110-Bacteriology; 200-Serology; 130-Parasitology; 300-Chemistry; 400-Hematology; 510-Blood Group and Rh and 520-Rh Titers; 610-Tissue and 630-Diagnostic Cytology.

Cicero Lake Laboratories, Inc., 4801 West Lake Street, Chicago, Illinois 60644 (Provider Number 14-8302) is no longer approved to perform Procedure 710-EKG Services, effective August 1, 1978. The laboratory is approved to perform Procedures 110-Bacteriology; 200-Serology; 310-Routine Chemistry; 320-Clinical Microscopy; 400-Hematology; 510-Blood Group and Rh; 630-Diagnostic Cytology.

Alpha Medical Laboratories, Inc., 7110 West 127th Street, Palos Heights, Illinois (Provider Number 14-8222) is no longer approved to perform Procedure 630-Diagnostic Cytology, effective August 1, 1978. The laboratory is approved to perform Procedures 100-Bacteriology; 200-Serology; 400-Hematology; 310-Routine Chemistry; 320-Clinical Microscopy; 710-EKG Services.

Kendon Medical Laboratory, Inc., 8625 South Cicero Ave., Chicago, Illinois 60652 (Provider Number 14-8052) is no longer approved to perform Procedure 330-Chemistry Other, effective August 1, 1978. The laboratory is approved to perform Procedures 110-Bacteriology; 300-Chemistry Routine; 200-Serology; 320-Clinical Microscopy; 400-Hematology; 710-EKG Services.

Avenue Medical Laboratory, 16234 St. Louis Ave., Chicago, Illinois 60743 (Provider Number 14-8050) is no longer approved to perform Procedure 120-Mycology, effective August 1, 1978. The laboratory is approved to perform Procedures 110-Bacteriology; 130-Parasitology; 200-Serology; 300-Chemistry; 400-Hematology; 510-Blood Group and Rh; 710-EKG Services.

Northbrook Community Laboratories, Inc., 1775 Walters Ave., Northbrook, Illinois 60002 (Provider Number 14-8023) is no longer approved to perform Procedure 330-Chemistry-Other, effective August 1, 1978. The laboratory is approved to perform Procedures 110-Bacteriology; 130-Parasitology; 200-Serology; 400-Hematology; 710-EKG Services.



Only Jobst supports are custom made from precise measurements of the individual extremity.

Jobst® Venous Pressure Gradient® Supports

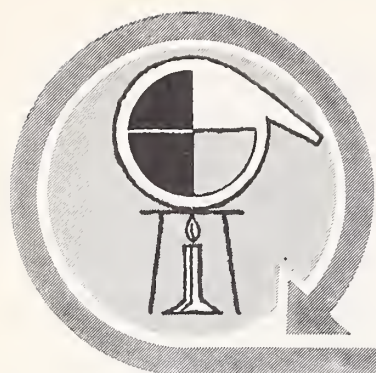
These measured, custom-made therapeutic elastic supports have carried the Jobst name to the four corners of the world. Prescription only, the supports can be engineered with counterpressures of 25, 30, 40 or 50 mm.Hg at the ankle, decreasing proximally along the venous pressure gradient. They are available in knee-length, full-leg, waist-height and lymphedema sleeve styles. The waist-height Jobst Pregnancy Leotard deserves special mention because each one is custom made with an expandable panel according to the patient's own measurements.

Contact your local Jobst Service Center for complete details.



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new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

New Single Drugs—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

COMBINATION PRODUCTS

ROBITUSSIN-DAC

Manufacturer: A. H. Robins Company
Composition: 5 ml contains
Guaifenesin 100 mg
Pseudoephedrine HCl 30 mg
Codeine Phosphate 10 mg
Alcohol 1.4%
Indications: Nasal congestion and cough
Dosage: One or two teaspoonful qid
Supplied: Bottle, pint

ANDRESTRAC 2-10

Manufacturer: Androgen/Estrogen Comb. Rx
The Central Pharmacal Co.
Composition: Each ml
Testosterone 10 mg
Estrone 2 mg
Sod. Carboxymethyl-cellulose 2 mg
Methylcellulose 0.2 mg
Providone 0.2 mg
Dioctyl sod. sulfosuccinate 0.15 mg
Indications: Postpartum breast engorgement
Dosage: im, cyclic administration
Supplied: Multiple dose vial, 10 ml

SK-65 APAP

Manufacturer: Non-narcotic analgesic Rx
Smith Kline & French
Laboratories
Composition: Propoxyphene HCl 65 mg
Acetaminophen 650 mg
Indications: Relief of mild to moderate pain
Dosage: One tablet every four hours
Supplied: Tablets

DEMI-REGROTON

Manufacturer: USV Laboratories
Composition: Chlorthalidone 25 mg
Reserpine 0.125 mg
Indications: Hypertension
Contraindication: Mental depression, severe renal and hepatic diseases
Dosage: Titrate individually, usual dose 1 tablet daily
Supplied: Tablets

MOBIGESIC

Manufacturer: Analgesic o.t.c.
B. F. Ascher & Co., Inc.
Composition: Magnesium salicylate 300 mg
Phenyltoloxamine citrate 30 mg
Indications: Pain associated with various conditions
Dosage: Depending on painful condition
Supplied: Tablets

SK-APAP With Codeine

Manufacturer: Narcotic Analgesic Rx
Smith Kline & French
Laboratories
Composition: Acetaminophen 325 mg
Codeine 15, 30 and 60 mg
Indication: Mild to moderate pain
Dosage: Adjust to severity of pain
Usual dose 1 to 2 tablets every four hours
Supplied: Tablets

TRIAMINICIN ALLERGY

Manufacturer: Antihistamine Cold Prep. o.t.c.
Dorsey Laboratories
Composition: Phenylpropanolamine HCl 37.5 mg
Chlorpheniramine maleate 4.0 mg
Indications: Temporary relief of nasal decongestion caused by allergy
Dosage: Depending on patient's response
Supplied: Tablets

NEW DOSAGE FORMS

ORNADE 2

Manufacturer: Nasal Decongestant o.t.c.
Smith Kline & French
Laboratories
Composition: Phenylpropanolamine HCl
Chlorpheniramine maleate
Indications: Relief of common cold
Dosage: Children: 1 teaspoonful q.i.d. for ages 6 to 12
1/2 teaspoonful q.i.d. for ages 2 to 6
Adults: 2 teaspoonfuls q.i.d.
Supplied: Bottles, 4 oz

Obituaries

****Abrahams, Samuel**, Chicago, died June 16, at the age of 80. He was a 1923 graduate of the University of Illinois and has held a position on the medical staff of Northwestern Memorial Hospital for many years. Dr. Abrahams was a co-founder of the Multiple Sclerosis Foundation of Chicago.

***Brown, Amos Jerome**, Chicago, died July 7, at the age of 57. He was a 1943 graduate of Northwestern University. Dr. Brown was the associate general medical director for the Western Electric Company and Michael Reese Medical Center as well as a member of several ISMS committees. He also served as chairman of the American Occupational Medical Assn. Committee on Alcohol and Drug Abuse.

***Green, R. Gregory**, Rockford, died July 11, at the age of 64. He was a 1942 graduate of St. Louis University. Dr. Green was a past president of the Winnebago County Medical Society and of the Central States Industrial Medical Society.

****Greenburg, Ira E.**, Florida, died June 9, at the age of 91. A 1910 graduate of Northwestern University, Dr. Greenburg had been a former secretary of the Englewood Hospital staff.

Littner, Michael M., Chicago, died June 30, 1978.

Moran, Clement J., Elmhurst, died April 25, at the age of 77. Dr. Moran was a staff physician and surgeon for 20 years at Hines VA Hospital.

****Pickett, William J.**, Chicago, died April 22, at the age of 85. Dr. Pickett was a 1916 graduate and staff physician at Loyola University Medical School. He was also affiliated with Cook County Hospital where he taught surgery and held a staff position.

Plank, Joseph Raymond, Marion, died May 2, at the age of 73.

***Schlicksup, Edward P.**, Peoria, died July 3, at the age of 59. He was a 1946 graduate of the Stritch School of Medicine. Dr. Schlicksup was chief of urology at St. Francis Hospital.

****Schmitz, Henry L.**, Florida, died June 27, at the age of 80. He was a 1926 graduate of Harvard Medical School. Before his retirement Dr. Schmitz was affiliated with Mercy Hospital and served as professor of medicine at Loyola University. He was also a fellow of the American College of Physicians.

Schwartz, Martin L., California, died July 6, at the age of 68. He was a graduate and later a trustee of the Chicago Medical School. Dr. Schwartz was a member of the staff at Michael Reese Hospital and director of the Abraham Levenson Foundation for mentally retarded children.

***Shay, Sujint S.**, Peoria, died June 19, at the age of 39. Dr. Shay was a 1964 graduate of Chiangmai Medical School, Thailand. He was a clinical professor of medicine at the Peoria School of Medicine and assistant medical director for cardiac care at Methodist Hospital of Central Illinois.

***Stearn, Anne M.**, Elgin, died July 1, at the age of 38. Dr. Stearn was a 1964 graduate of Cornell University.

***Stearn, Burton**, Elgin, died July 1, at the age of 43. He was a 1962 graduate of Northwestern University. Drs. Anne and Burton Stearn who, shared a career in medicine, both specialized in otolaryngology. The Stearns' deaths resulted from a tragic airplane crash.

****Stevenson, Edgar McLean**, Bloomington, died July 8, at the age of 80. Dr. Stevenson was a 1923 University of Michigan graduate. During his career as a physician he received many awards, including the Spirit of McLean award and the Edgar Stevenson Hall at the Illinois Wesleyan University, which was dedicated in 1965. Dr. Stevenson was a former president of the McLean County Medical Society and a staff member at Brokaw Menonite and St. Joseph's Hospital Medical Center.

***Sokolowski, Joseph F.**, Chicago, died July 19, at the age of 76. He was a 1929 graduate of the Stritch School of Medicine.

Vinci, Anthony J., Chicago, died April 19, at the age of 64.

Winston, W. Maurice, Phoenix, died May 30, at the age of 80. Dr. Winston was a practicing physician in Chicago Heights and Harvey.

**Indicates ISMS member.*

***Indicates member of the ISMS Fifty Year Club.*

CHIEF PHYSICIAN

Full time position with major South Chicago industrial concern, located conveniently to city or south suburban living.

Complete in-plant facilities with nearby consultative and hospital services available.

In addition to attractive compensation, this position carries an excellent corporate benefits package.

Please reply with curriculum vitae and/or professional history to Box 932, IMJ, 55 E. Monroe, Suite 3510, 60603.

An Equal Opportunity Employer M/F

IN THE ILLINOIS AREA, STAPH RESISTANCE HAS NOW REACHED 79%.*

resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

TEGOPEN[®] (cloxacillin sodium)

“THE PENICILLIN OF TODAY”

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.
- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary
for prescribing information.

Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution
For complete information, consult Official Package Circular.

(12) TEGOPEN 9/11/75
Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q. 6h.

Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

Ask the Consultant

"Ask the Consultant" is a new IMJ feature. Readers are encouraged to write with clinical questions for which they have not been able to find solutions. The questions will be forwarded to the IMJ Editorial Board. Board members will provide responses, or find specialists to find solutions. Interested readers are asked to write IMJ, 55 E. Monroe, Suite 3510, Chicago 60603. Please specify that your question is for the "Ask the Consultant" column.

What can be done to reduce the risks in non-cardiac surgery in patients with coronary artery disease?

In spite of much improvement in anesthesia and surgery in recent years and the improvements in post-operative care, morbidity and mortality remain inordinately high in non-cardiac surgical procedures for patients with coronary artery disease as compared to patients of similar age without heart disease. These patients with a damaged cardiovascular system are prone to more risk with any surgical procedure. The hypotension, hypoxemia, infection and thrombo-embolic problems often associated with surgery are especially hazardous in an already damaged heart.

Realizing all this, careful monitoring of cardiac and hemodynamic status both during and after surgery to avoid hypotension, volume overload and maintain IV fluid requirements with stable cardiac rhythm, will permit surgery to be done without undo risk.

Avoid digitalis when there is no congestive failure or atrial tachycardia in the operative period. Usually a temporary pacemaker may not be needed and propranolol may gradually be discontinued. If cardiac surgical expertise is available, sometimes bypass surgery would be desirable before the non-cardiac surgery is done. (For more information, see: Hills L. David, Cohn Peter F.: "Noncardiac Surgery in Patients With Coronary Artery Disease," *Arch. Internal Med.*, 138:972, 1978.)



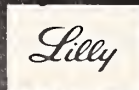
BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

contains no aspirin

tablets
Darvocet-N[®] 100 (IV)

100 mg. Darvon-N[®] (propoxyphene napsylate)
650 mg. acetaminophen

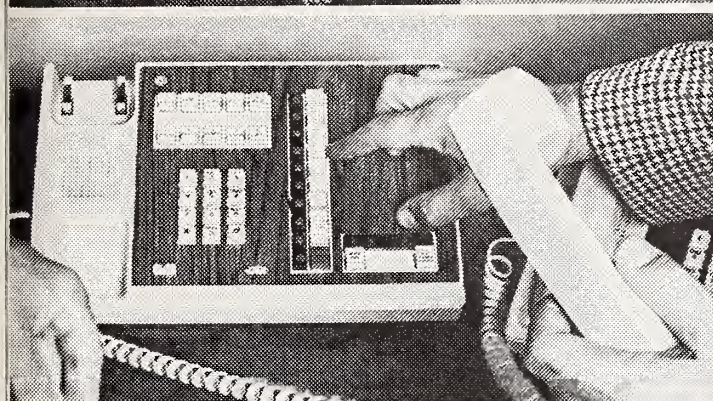
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700565

Additional Information available
to the profession on request from
Eli Lilly and Company
Indianapolis, Indiana 46206

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630



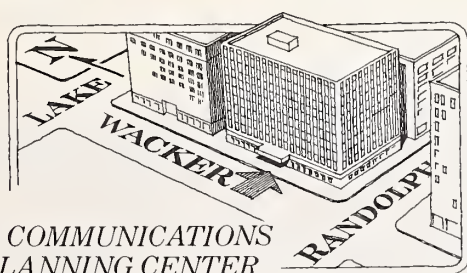
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Carcinoma Arising In a Thyroglossal Duct Cyst

BY PHILLIP L. CACIOPPO, M.D. AND MOHIN T. SAMARAWEERA, M.D./
EVANSTON AND CHICAGO

Primary carcinoma arising in a thyroglossal duct is rare, but this case again demonstrates the necessity for excision of all thyroglossal duct remnants. The differentiation of midline and lateral ectopic thyroid tissue is discussed.

Although rare, carcinoma arising in the thyroid tissue present in a thyroglossal duct cyst has been long recognized. The true pathology is seldom diagnosed preoperatively. It is seen in a female to male ratio of 2:1.¹ Most are papillary

lesions, other histologies have been reported.²

Case Report: A 24-year-old white female presented with the history of a midline upper neck mass increasing in size over the seven months prior to admission. No pain or dysphagia was associated with the mass. The clinical impression was that of a thyroglossal duct cyst. Pre-operative I¹³¹ radioisotope thyroid scan and function studies (T₃ and T₄) were normal. At exploration the mass appeared cystic and lobulated, in the classic location for a thyroglossal duct cyst. There was no attachment to the thyroid gland. An enlarged adjacent lymph node was hyperplastic without tumor, and a standard Sistrunk procedure was performed.³ Grossly, the cyst was multiloculated and filled with yellow gelatinous material. The lining was smooth except for one focus of friable papillary material adjacent to the hyoid bone. Histologic diagnosis was that of mixed papillary and follicular adenocarcinoma, predominantly papillary, containing psammoma bodies with normal thyroid tissue present. (Fig-

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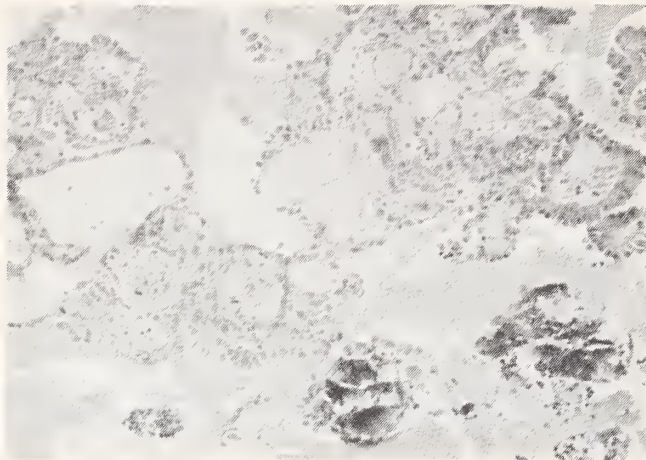


Figure 1

Photomicrograph showing mixed papillary and follicular adenocarcinoma of thyroid tissue. Psammoma bodies are present.

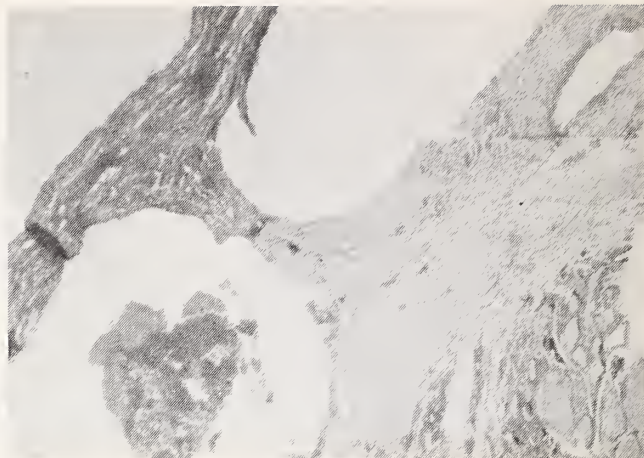


Figure 2

Photomicrograph showing cystic component and normal thyroid tissue.

ures 1 and 2) There was no extension through the cyst wall, which was lined by cuboidal epithelium.

Discussion

The occurrence of carcinoma arising in a thyroglossal duct remnant has been shown to be one in 128 by Nachlas⁴ and two in 130 by Choy.⁵ Since thyroglossal duct cysts are unusual the finding of carcinoma is exceedingly rare. An excellent review of the entire subject by LiVolsi *et al.*,⁶ found normal thyroid tissue in varying amounts up to 64%. Although lateral ectopic thyroid tissue is accepted as metastatic disease, midline ectopic thyroid is considered benign unless specific histologic evidence of malignancy is noted. Most carcinomas arising in median ectopic thyroid tissue are papillary adenocarcinoma.^{1,2} Significant other histologies, however, including squamous cell carcinoma and mixed papillary and follicular carcinoma, have been included in 21% of cases reported by Bhagavan.²

Controversy has arisen only in distinguishing true ectopic thyroid tissue from metastatic cystic carcinoma. In the presence of normal thyroid tissue at the site of the lesion, it is reasonable to assume that carcinoma has arisen in ectopic tissue.⁷

Management

The management of a carcinoma arising in a thyroglossal duct cyst is basically the Sistrunk procedure³ with evaluation of the adjacent nodal

tissue and of the thyroid gland with careful post-operative monitors for local recurrence. Presence of suspicious or positive nodes should be the criteria for nodal dissection. If the thyroid gland is normal to palpation and scan, it is generally felt that total thyroidectomy is not advised.^{1,2,6} If the thyroid gland is abnormal, then the lesions must be treated as a primary thyroid neoplasm or at least a multicentric disease. Survival is excellent with this plan of management.^{1,6} The care of this disease as in adenocarcinoma of the thyroid gland itself must be continued over a 20-year followup because of the natural history of adenocarcinoma originating in thyroid tissue.⁸ ◀

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The University Medical School

Reaching to the Community Physician

BY RICHARD L. BYYNY, M.D., LINDA K. GUNZBURGER, M.S., CHASE P. KIMBALL, M.D.,
MARK SIEGLER, M.D., AND ALVIN R. TARLOV, M.D./CHICAGO

In our new era of health care planning and system implementation, the University of Chicago is establishing a regional network of community hospitals which provides a means by which continuing medical education is available to the practicing community physician. Based on a firm academic tradition, the Medical School has found it necessary to form relationships with community hospitals. These relationships not only provide learning programs for physicians but offer valuable learning experiences for medical students, interns, and residents. To obtain quality health care it is necessary to extend the education in medicine beyond the walls of the medical school. Through joint cooperation the university physician can aid the community physician in management of difficult cases and in referrals. However, the community physician is needed to provide the setting and guidance depicting primary and secondary community health care.

This is a time when the attention of the nation and medicine in general is turning toward the organization of health resources in an effort

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to distribute these more efficaciously for the prevention, detection, and remediation of illness and disease. Academic centers geared to address themselves, their faculties and services to the technology of the biomedical revolution of the past quarter century may suddenly find themselves helplessly deficient in their wherewithal to face what are doubtless the major challenges of the next quarter century.

As the University of Chicago, similar to other major universities, emerges into this new era of health education, research, and service it finds its resources in most every respect woefully inadequate to help plan for and synthesize plans to accommodate itself to the changing social and consequent political and financial patterns of this medical evolution.

Academic medical centers will become increasingly involved in all levels of education and training. This will require simultaneous solutions to problems regarding the type of students appropriate for such careers, the setting in which they should be taught, the content of their education and training and the allocation of public and private resources to this enterprise. However, the critical component in this process will be the teachers. It is this group which must select future students, create model settings in

which they are to be taught, define a curriculum relevant to the needs of their patients, provide opportunities for continuing education and training which focus on improving the outcome of patient care, and assure that sufficient resources are available to carry out these tasks.¹

It is within the frameworks of continuity and change that we believe many university medical schools in the 1970's share common features, including abiding commitments to excellence in the care of patients, in the training of undergraduate and postgraduate students, and in the discovery of new information through basic and clinic research.² Thus, it is our hope that the experience at the University of Chicago will be helpful to other medical schools as they develop within their own unique settings an approach to a pressing need in medical education in the 1970's, the strengthening of training programs.

The University of Chicago System— Background

A medical school at the University of Chicago was not established until 1927, although one had been proposed even before the university was founded in 1893. This 34-year delay between conception and realization allowed the developers of the medical school to create an institution whose organization incorporated major advances in American medical education and also reflected the philosophical orientation of the University of Chicago. The unique organizational features of the new medical school included a true university medical school; a true full-time, fully-salaried medical faculty; university ownership and management of a general hospital with both inpatient and outpatient facilities; a major commitment to research and the generation of new information within the context of patient care and clinical teaching and a belief in a functional division of labor within medical school departments.

This pattern of organization resulted in a remarkably effective system of medical education and practice, which lent itself easily to the introduction of innovations and change. Thus, for example, in 1928 the Department of Medicine at the University of Chicago incorporated the subspecialty system of practice, which antedated by two decades the national movement in this direction. Following World War II the existence of strong subspecialty sections within the department of medicine proved an ideal arrangement for capitalizing on the availability of

government funds for research and training, and the system was further strengthened. These funds were usually dispensed through categorical institutes of the NIH, and categorical sections of a large department of medicine were able to compete with special effectiveness for these grants.

Forty years of experience with the subspecialty system has allowed the University of Chicago ample opportunity to appreciate the strengths and weaknesses of this system.³

Community Hospitals Relationships

Three years ago, general internal medicine initiated relationships with several community hospitals to the south of the university for the purpose of assisting them in continuing medical education programs in their hospitals, as well as for the purpose of fostering referral of patients to the university hospital. This program has subsequently grown in scope to include many of the clinical departments and is now coordinated by a multi-departmental committee on community health affairs and hospitals appointed by the Dean. The educational programs in each of six community hospitals are coordinated by one member of the faculty from the university, five of whom are of the Department of Medicine, two of these from the section of general internal medicine.

Since 1972, we became interested in developing mutually beneficial relationships with hundreds of privately practicing physicians and their hospitals. The physicians, and their patients most accessible to us were to the south and southwest in a 30 mile semicircle of the university. Contact was made through the hospitals where these physicians were privileged. Programs have been developed whereby we provide continuing education (lectures, grand rounds, clinical pathological conferences) for the medical staff in their hospital, and in turn the physicians use our staff and facilities for consultation and for direct transfer of patients requiring tertiary, or complicated, care.⁴

Office of Postgraduate Medical Education

With funding from the National Fund for Medical Education, the University of Chicago was able to establish an Office of Postgraduate Medical Education in 1974 and begin to conceptualize an advanced training program in general internal medicine. The Office enables the synthesis and integration of all present post-

graduate activities and continuing education programs in health related services at the University of Chicago.

These programs serve to bolster the community hospitals' attempts to recruit younger staff members, but also keep general physicians abreast of contemporary developments in medicine, surgery, obstetrics-gynecology and psychology. The university departments have also established consultation activities at these hospitals.

The Office is also planning refinements in the educational program, particularly in the area of methodology. Utilizing a now basic methodological approach to the field of continuing medical education, each of our coordinators, with the assistance of our Department of Education, is attempting to determine the specific needs of the medical staff in each of these hospitals and to develop the objectives of the educational program based upon these.

The university has taken the initial steps necessary for implementing the Office of Postgraduate Medical Education. The educational program director brings expertise in educational methods to the content program that our consultants identify. Such an individual assists coordinators and consultants in selecting appropriate methods by which to convey content material. In addition, the director identifies those areas within a given hospital program where integration and synthesis could be achieved. As programs are developed at several hospitals, the director will identify in what ways individual hospital programs might be related to one another. For example, in the event that several hospitals develop family medicine residency programs, it is possible that part of the didactic course work in these programs might be given on the university campus.

The program director is responsible for the intramural continuing education program at the University of Chicago and is challenged to seek ways to relate these to the extramural programs. Similarly the director works with other programs coordinated by the Committee on Community Health Affairs and Hospitals, e.g., the cancer control program. The director is expected to devise methods of evaluating the educational and referral programs and to assist in whatever investigative activities the committee might propose for evaluating health needs and resources in the area of a particular community hospital. The director inaugurates and/or participates in grant applications to private and public agencies with

a view toward developing resources of the Office and in developing the advanced training program in General Internal Medicine.

Advanced Training Program in General Internal Medicine

The section of general internal medicine has established a two-year advanced training program which is designed to prepare internists for positions in academic general internal medicine, or for positions as directors of medical education in community hospitals. Three years of training in internal medicine (internship plus two years of residency) is a prerequisite. The objectives of the training program include the definition and development of the skills of a general internist, the acquisition of skills and techniques of education, training in the methodology of evaluation research, and experience in the organization and utilization of biomedical information systems.

The development of outstanding clinical skills will be emphasized because we believe that the most effective general internal medicine educator will be one who is acknowledged by students and colleagues to be an exceptionally skillful physician. This program will not merely extend the existing residency program, but will concentrate in areas that are not well treated in the present residency. These special areas include training in the organization and management of more effective ambulatory internal medicine; the heretofore underemphasized skills and responsibilities required of a principal physician to solicit, coordinate and clinically evaluate the opinions and recommendations of multiple consultants in a complex medical situation and arrive at a wise course of action; a special awareness and knowledge of clinical pharmacology which would allow one to practice and teach a more precise and scientific therapeutics; the organization and direction of intensive care units; and experience in the special knowledge and techniques required for effective consultation on surgical patients.

The acquisition of the skills and techniques of education will be an important part of the advanced training program. The expertise of the Department of Education at the university will be enlisted to instruct the trainee on methods of planning, teaching, and evaluating programs in undergraduate, graduate and postgraduate education.

Instruction will be provided in the methodology of evaluation research and cost-benefit anal-

ysis, and its application to health-care systems and to quality-care assessment. The instruction in these areas will be provided by the School of Social Service Administration and the Center for Health Administration Studies of the Graduate School of Business, at the University of Chicago.

In cooperation with the School of Library Science, the trainees will gain experience in the planning, organization and management of libraries and biomedical information systems.

Finally, all trainees will be required to undertake independent investigation in one of the areas emphasized above. Some of the trainees may wish to pursue an advanced degree (either a Masters or a Doctorate) in one of the departments of the university affiliated with this program.⁵

The Need for a Regional Approach

Primary medical training cannot adequately be incorporated only within its campus clinics, or in medically underserved areas without addressing the varying health concerns of inner-city and non-urban communities. While significant resources have been directed since the mid-1960's into inner-city areas, little substantive work has been accomplished in the smaller, non-urban communities. Concern is for programs that link non-urban area institutions with the resources of the university medical center. Coordination of urban and more distant non-urban institutions of necessity requires planning and resource allocations from a regional perspective.

The university considers that a) development of "communiversity" relationships will favorably support its on-campus teaching and research requirements for large, referral specialty patient populations, and b) provide off-campus opportunity for its faculty and students in the areas of health policy planning and research.⁶

Conclusion

By our regionally reaching to the community physicians, their continuing education would be built into the character of their professional lives, and would become natural, a habit. They could assist in teaching our students and residents within their own practices, they might attend conferences, seminars, and courses at the University Hospital, and they would undoubtedly

ly use our subspecialty consultation services and refer patients to the university for specialized care. The epidemiology and demography of illness in their setting may provide research opportunities for scientists at the university. ◀

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Seminars In Immunopathology and Oncology

RICHARD J. ABLIN, PH.D., CONTRIBUTING EDITOR

Immune Complexes and Human Disease

BY BRIAN S. ANDREWS, BSc (Med) AND RONALD PENNY, M.D./SYDNEY, AUSTRALIA

This is the first of three parts in a special overview series for the "Seminars in Immunopathology and Oncology." In part one, Doctors Penny and Andrews delineate the historical background to immune complex research. Part two, exploring detection of immune complexes, will be published in the September IMJ.

When a foreign, exogenous antigen enters the body, a specific binding protein (antibody) is formed to eliminate it. Under normal circumstances, the combination of antigen (Ag) with antibody (Ab) results in the formation of an immune complex (IC) which is rapidly cleared from serum and tissues by the phagocytic system. However, complexes sometimes continue to

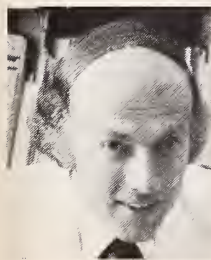
circulate, deposit on vascular basement membranes and result in an inflammatory reaction. In other situations, endogenous or auto-antigens are associated with formation of excessive quantities of Ab resulting in similar ICs and typified by systemic lupus erythematosus (SLE).

As IC formation represents a normal immune clearance mechanism for Ag, it is clear that circulating IC's only result in clinically overt disease under certain circumstances. If ICs are to be incriminated in the pathogenesis of a specific disease, certain ideal criteria should be established: (a) an Ag should be identified; (b) an IC containing both Ag and Ab should be demonstrated in serum and tissues; (c) the pathogenic nature of the circulating IC should be established, *e.g.*, ability to activate complement (C); and (d) the level of circulating ICs should parallel clinical disease activity.

Acute serum sickness represents the prototype of a human IC disease produced by an exogenous Ag. It was first described in 1905 by von Pirquet and Schick¹ who proposed the basic underlying mechanisms. These were subsequently validated by both Germuth² and Dixon and colleagues.³ Rabbits were immunized with a single large injection of bovine serum albumin ("one shot serum sickness") and at the onset of Ab production developed an acute serum sickness reaction.



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Abbreviations

Ab	Antibody
Ag	Antigen
C	Complement
IC(s)	Immune Complex(es)
Ig	Immunoglobulin
GN	Glomerulonephritis
MPS	Mononuclear phagocytic system
PEG	Polyethylene glycol
PMN	Polymorphonuclear leukocyte
RA	Rheumatoid arthritis
RF	Rheumatoid factor
RIA	Radioimmune assay
SLE	Systemic lupus erythematosus

This was characterized by a proliferative glomerulonephritis (GN) and generalized necrotizing vasculitis, associated with circulating and tissue ICs and reduction in total hemolytic C. The components of the circulating IC, namely bovine serum albumin, rabbit Ab and C were identified within the glomerulus and vessel walls. While the polymorphonuclear leukocyte (PMN) com-

prised the predominant inflammatory cell in the vasculitic lesions, marked endothelial proliferation without a cellular infiltrate characterized the glomerular lesion. As this model was not representative of the typical acute GN in humans, an attempt was then made to produce a more representative model in rabbits using daily injections of bovine serum albumin. The aim was to maintain a continuous level of circulating antigen-antibody complexes.⁴ Chronic serum sickness developed when circulating complexes persisted for more than two weeks. In contrast to the acute serum sickness model, the glomerular lesion was associated with a marked cellular infiltrate and electron dense basement membrane deposits which persisted for six to twelve months following cessation of the antigenic challenge.

Thus, an IC disease was produced in experimental animals by the introduction of an exogenous Ag. Circulating IC's were formed which were able to activate serum C and result in a tissue inflammatory reaction. The latter, however, was influenced by the nature and the quantity of circulating IC's.⁴

Immune Complex Disease in Animals

Chronic viral infection in genetically susceptible animals may result in IC disease, usually manifested as GN and vasculitis. Commonly recognized viral agents in the mouse include lymphocytic choriomeningitis, lactic dehydrogenase and a variety of oncornaviruses. In the horse, "equine anemia" virus has been identified and in the mink, "Aleutian disease" virus.⁵

The New Zealand Black/White Fl hybrid female mouse chronically harbors oncornaviruses and develops a disease similar to human SLE associated with severe proliferative GN. Impaired T-cell function in these mice may be related to either reduced suppressor T-cell or increased helper T-cell activity leading to B-cell over-activity and excessive Ab production. Antibodies are directed against exogenous [viral] and endogenous [nuclear, T cell, erythrocyte] antigens and may result in the formation of circulating ICs.⁶ In two further murine models, the BXSB and the MRL/l, circulating ICs have been identified by the Raji cell radioimmunoassay (RIA), mixed cryoglobulins and C activation.⁷ Immune com-

plex GN and vasculitis result in death by four to five months. In the BXSB, there is a clear male predilection whereas a slight female predilection exists in the MRL/l.

Viruses may persist in the circulation as ICs, maintain their infectivity and ability to replicate, and act as a continual source of Ag in the production of circulating viral Ag-Ab complexes.⁸ Oncornaviral Ag's incorporated into the host genome in man and mouse may result in formation of antigenic nuclear material. This material, composed of host and viral nucleic acids, may be able to elicit an Ab response in the host.

Conversely, genetic factors may predispose to chronicity of viremia and expression of an IC disease. Predominance of male disease in the BXSB, early onset of IC disease in New Zealand Black/White Fl males following castration and delayed disease onset in castrated females together with the female predominance in human SLE, all suggest a hormonal influence in the modulation of disease expression.⁹

Factors Influencing the Development of an Immune Complex Disease

(A) Clearance of Circulating Immune Complexes

(1) *The nature of the immune complex:* Most circulating ICs appear to be cleared from serum by fixed and circulating mononuclear phagocytic cells which possess C and Fc surface receptors. Pathogenetic ICs sometimes deposit on vascular basement membranes, activate serum C and initiate an inflammatory cellular infiltrate. Pathogenic complexes (19S, MW 10^6 daltons) usually are soluble,¹⁰ not readily phagocytosed and circulate in slight to moderate Ag excess.¹¹ Larger complexes are quickly cleared by the mononuclear phagocytic system (MPS), while smaller non-C fixing complexes (7S) are cleared by spleen although they may also be fixed in glomeruli, blood vessels and choroid plexus.¹² Low affinity Ab containing complexes appear to be less efficiently cleared by the MPS.¹²

With respect to the antigenic moiety, large Ag's (e.g. viral particles, circulating DNA) may be rapidly eliminated without Ab while a small single dose of Ag (e.g., bovine serum albumin) may not persist in sufficient quantities to form pathogenic complexes when Ab is produced.¹³ Potent Ag's evoke a high titer antibody response where IC disease is unlikely to develop, usually with rapid Ag elimination. In addition, weak Ag's may result in formation of pathogenic complexes via production of reduced amounts of Ab and/or low affinity Ab.¹⁴ A low affinity Ab response may be genetically determined via linkage to the immune response (Ir) gene, and in this respect, IC disease may have a genetic basis. Although it is tempting to speculate on the quantity and function of the Ab produced, in particular the relationship to the gene, there is only sparse data linking the HLA system in man with the development of IC disease.¹⁵

(2) *Mononuclear phagocytic system (MPS):* This name replaces the older term, reticulo-endothelial system, and refers collectively to circulating monocytes and fixed tissue macrophages. Clearance of ICs by the MPS appears to be a function of the degree of lattice formation and the presence of specific Ig subclasses IgG₁ and IgG₃ within the complex.¹¹ In experimental serum sickness, 99% of ICs are eliminated by the MPS, predominantly by hepatic Kupffer cells, leaving less than 1% to produce any tissue

damage.⁴ In man, unlike the experimental animal, it cannot be assumed that the MPS is fully functional at the onset of clinical IC disease. Clearance of ICs appears to be independent of C receptor binding and requires an intact Fc region on the IgG within the complex for recognition by the MPS surface Fc receptors.¹⁶ At the onset of acute serum sickness, hepatic Kupffer cells are saturated by ICs and are unable to clear further circulating ICs, allowing complexes to remain for longer periods in serum.⁴ Corticosteroids prolong the circulation time of injected performed ICs.¹⁷ In chronic serum sickness GN, steroids increase the uptake of ICs by the glomerular mesangium possibly by decreasing basement membrane permeability to the ICs.¹⁸ It is possible that the most philogistic IC's may never enter the circulation or if so are rapidly removed such that the ICs detected in serum may only reflect the presence of injurious complexes in other tissue sites.

(B) Mechanisms of Immune Complex Localization in Tissues

Immune complex deposition on vascular basement membranes appears to coincide with a local increase in capillary permeability. This may result from (a) vasoactive amines released locally from basophils and platelets producing endothelial retraction¹⁹ or (b) endothelial damage related to ischemia or ongoing inflammation.²⁰ Once the vascular integrity is breached by an inflammatory process, circulating complexes are probably readily deposited. Immune complexes do not appear to adhere to nor do they appear to be phagocytosed by vascular endothelium although if endothelial C and Fc receptors existed, these could help to localize complexes. Demonstration of glomerular C3b receptors,²¹ although localized to the epithelial side of the basement membrane,²² may still contribute to IC localization.

Various non-immunologic factors are involved in IC deposition. These can be readily appreciated in human leukocytoclastic vasculitis, where IC deposition is most prominent in the lower limb and over areas of pressure.²³ Prolonged contact time between endothelium, circulating cells, especially platelets, and ICs appears to influence IC deposition. A reduced dermal capil-

lary blood flow rate may follow (a) an increase in intravascular and intracapillary pressure (gravity, venous obstruction), (b) reduced body surface temperature, (c) a local increase in blood viscosity and (d) vasodilation. A propensity to intravascular coagulation with fibrin deposition and platelet aggregation is associated with decreased flow rate.²³ Endothelial damage *de novo* may result in decreasing plasminogen activator synthesis leading to impaired local fibrinolysis and decreased clearance of fibrin deposits.²⁴

The anatomy of the local circulation influences IC deposition. Glomerulus, choroid plexus, synovium, and uveal tract share a high blood flow/unit tissue mass and all produce an ultrafiltrate of plasma. These sites can potentially trap large quantities of circulating ICs and are high risk sites in man. A charge similarity between Clq and exposed collagen in vascular basement membranes based on similar amino acid sequences may allow circulating Clq reactive complexes to bind to exposed collagen, secreted in part by endothelial cells.²⁵

(C) Mediators of Immune Complex Induced Inflammation

(1) *Platelets*: Human platelets possess receptors for the Fc portion of IgG but not for C3.²⁶ Complexes appear to bind to circulating platelets, resulting in aggregation and release of nucleotides, vasoactive amines and the pro-coagulant platelet factor three.²⁷ In addition, thrombin, ADP, exposed collagen, prostaglandins, and platelet-activating factor (PAF), which is released from basophils and mast cells, can all cause platelet aggregation.²⁸ Basic proteins released from platelets and PMNs are capable of increasing vascular permeability. While the role of platelets in human IC deposition is unclear, they are involved in IC deposition in experimental acute serum sickness.²⁷ Pretreatment of experimental animals with antihistamines reduces IC deposition.²⁰ Cyproheptadine or hydroxyzine chloride, used in a diphtheria epidemic in conjunction with diphtheria anti-toxin, reduced the

incidence of serum sickness reactions by seven fold over that which developed in controls.²⁹ This observation suggested that the vasoactive amines, histamine and serotonin, did play a role in IC deposition in man.

(2) *Polymorphonuclear Leukocytes*: PMNs comprise the dominant primary cellular response to tissue ICs. Their entry is mediated via components of the C system.³⁰ In the Arthus reaction, PMNs predominate in the four hour lesion and are progressively replaced by mononuclear cells, comprising 50% of the cellular infiltrate by 24 hours. However, cutaneous allergic vasculitis in man is associated with a prolonged PMN tissue response which persists together with tissue ICs for up to four days.³¹ This difference may be related to continual IC deposition or to local IC formation or possibly a superimposed Schwartzmann-type reaction. Experimentally induced neutropenia or thrombocytopenia abolishes the generalized vasculitis in the acute serum sickness model, but does not influence the GN. This would indicate that PMNs or platelets are not a prerequisite for the renal lesion.³²

PMNs undergo chemotaxis to the site of IC deposition under the influence of C567,* C5a and to a lesser extent C3a.³³ In addition, other less potent chemotactic agents are liberated during the inflammatory process (basic lysosomal proteins, kallikrein, plasminogen activator, fibrin degradation products).³³ Complexes bind to Fc and C3b receptors on the neutrophil. They undergo phagocytosis which results in a release of lysosomal enzymes.³⁴ Extracellular release of lysosomal contents (collagenase, elastase, cationic proteins, hydrogen ions, etc.) and possibly superoxides, singlet oxygen and peroxide cause further tissue damage and exacerbate the inflammatory response. These increase vascular permeability, degranulate mast cells and initiate *in vivo* coagulation via thromboplastin generation.^{35,36}

(3) *Complement System*: Immune complexes activate the classical and alternative C pathway, with the former generally predominating. Complexes containing IgM and IgG (especially IgG₁ and IgG₃) activate the classical C pathway while IgA complexes, like zymosan, endotoxin and initiating factor (factor I) the alternative C pathway.³⁷ The presence of the early sequence components Clq, C4 and C2 at this tissue site indicate classical pathway activation. Properdin factors B and D indicate alternative pathway activation.³⁸ Large amounts of C3 are detected in tissues undoubtedly because C3 represents the

*The asterisk indicates the activated state of the molecule. (Standard World Health Organization Nomenclature is a bar over the molecular symbol as shown in the figures herein. Because reproduction of this nomenclature in the text was not feasible, the bar is herein represented by an asterisk.)

amplification step in the C cascade with the highest level of any C component in serum.

Activation products of C are responsible for:

- C3b mediated immune adherence of ICs to PMNs, eosinophils, and mononuclear phagocytes.³⁷ C4b plays a lesser role in immune adherence. In addition, binding of ICs via a C receptor can result in exocytosis of lysosomal granules;

- Chemotaxis of leukocytes mediated via C567,* C5a, and C3a.^{33,37} It has been implied that C fragments may also be associated with lymphocyte chemotaxis;³⁹

- Formation of the anaphylatoxins C3a and C5a, which lead to release of granules from basophils and mast cells;³⁷

- Cell lysis from surface binding of the terminal C components either following direct binding of Ab to an Ag on the cell surface or via a "bystander reaction" where preformed ICs passively bind to the cell membrane leading to C activation;

- Activation of B-lymphocytes by C3 breakdown products.⁴⁰

(4) *Coagulation, fibrinolysis and the kinin system*: While earlier evidence suggested that ICs could activate Hageman factor (Factor XII) directly resulting in coagulation, this now appears not to be so.⁴¹ However, the role of ICs with fixed C1q have not been fully studied with respect to their ability to bind factor XII.⁴² Indirectly initiated coagulation resulting from thromboplastin generation, release of lysosomal contents or via exposure of basement membrane collagen appears to be the chief mechanism for *in vivo* coagulation.³⁶ The proteolytic enzyme plasmin in addition to degrading fibrinogen-fibrin complexes appears to generate kinins and activate the C system by proteolysis of C1 and C3.⁴²

(5) *Lymphocytes*: Experimentally, ICs may suppress and enhance lymphocyte activation.^{35,43,44} At the B-cell level, IC's can modulate B-cell function depending on the stage of differentiation and the nature of its surface receptors. In general, ICs result in B-cell inactivation⁴³ requiring for this action an intact Fc region on the Ab. This suggests that B-cell inactivation occurs by binding of the IC to the lymphocyte Fc receptor. In addition, excess quantities of Ag or ICs presumably related to the complexed Ag can inhibit specific Ab production by lymphocytes.

With respect to T-cell function, ICs similarly appear to inhibit overall T-cell function. They

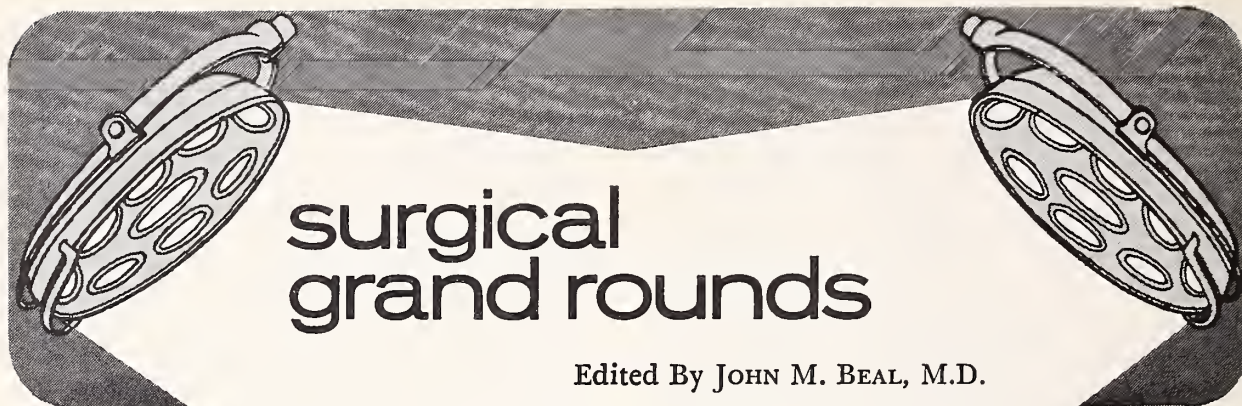
may do so by inhibiting helper T-cell activity or by activation of suppressor T-cells.⁴⁵ Recent T-cell subsets have been found to bind the Fc region of IgM (Tu)⁴⁶ or the Fc region of IgG (Ty).⁴⁶ Binding of ICs containing IgM or IgG antibody may thus lead to the generation of helper or suppressor cell activity respectively. In addition, ICs may abrogate the proliferative response of mouse spleen cells to both B- and T-cell mitogens.⁴⁷ ICs immobilized on plastic surfaces inhibit blastogenesis, while suspensions of the same ICs are not inhibitory.⁴⁸

With respect to the effect of ICs on lymphocyte function in human disease, most data relates to their role as "blocking factors" in malignancy.⁴⁷ Immune complexes may inhibit the T-cell cytotoxic response to tumor cells by specific activation of suppressor T-cells. They may inhibit T-cell function by binding the complexed tumor Ag to the T-cell surface antigen receptor. Third, they may inhibit B-cell function and Ab production by cross-linking B-cells via binding to their receptors.³⁵

The role of the tissue lymphocyte in IC-mediated tissue injury is unclear. However, it has been demonstrated that B-type lymphoblastoid cells and activated T-lymphocytes undergo chemotaxis to C components and specific Ag respectively.⁴⁷ In cutaneous lymphocytic vasculitis, a perivascular lymphocytic infiltrate is associated with IC deposition, but again lymphocyte function is unknown.^{48,49}

Further, ICs may modulate the immune response via the formation of anti-idiotypic Ab.⁵⁰ These Ab's bind to the Ag combining sites on specific Ab and in addition react with the Ag receptor on the lymphocyte surface.⁵¹ Thus, ICs can possess anti-receptor activity with their binding leading to impaired function of a specific receptor-bearing cell which may be either B- or T-cell.

This concludes part one of our three part series on immune complexes and human disease. Part two is scheduled for the September issue. A complete list of references is available upon request to: Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago 60603.



Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of June 7, 1977.

Computerized Whole Body Tomography

Dr. Harvey L. Neiman: In 1972, Godfrey Hounsfield and his co-workers at the EMI laboratories in London, England, announced the development of the first computerized tomographic unit for clinical use. This first generation machine was a dedicated brain scanner, and systems for scanning other parts of the body were developed shortly thereafter.

The clinical unit for brain scanning was actually quite crude in the sense that the scanning times were very long—on the order of five minutes. Time for reconstruction of the image was also very long, and therefore the clinical applications of this method were limited. The possibilities of whole-body scanning were theoretically so exciting, however, that numerous technical advances proceeded rapidly, such that scanning times are now in the 2 to 20 second range in clinically available units.

I would like to briefly review the concept of CT scanning, a little about the physics, and then primarily to discuss case material which is illustrative of the present clinical indications. CT scanners are conceptually similar and the major components of all manufacturers' products have much in common. This discussion applies to most of the currently available CT models.

In a CT system, the patient is placed in the center of an X-ray gantry. The gantry houses an X-ray tube and a series of detectors which are directly opposite the X-ray source and which have the ability to move synchronously with it.

The detectors are of two varieties. Scintillation detectors consist of a luminescent crystal such as activated sodium iodide or bismuth germinate and an optically coupled photomultiplier tube. Gas detectors, usually xenon, can also be utilized.

Presently, the most commonly utilized instrument uses a fan shaped beam of X-rays which has an angle of 10° . To obtain a cross-sectional image, the X-ray source, as well as a group of 30 detectors, move synchronously in a linear fashion across the patient. The X-ray tube and detectors are then rotated 10° and the procedure repeated until the volume of tissue is viewed from 180° . This system allows the completion of a scan in under 20 seconds.

Head scanners can utilize longer scanning times, since motion can be prevented by stabilizing the head. In the abdomen and chest however, faster scans are needed to prevent motion unsharpness from peristaltic activity, respiratory motion, etc. A "third generation scanner" utilizes a fan shaped beam of approximately 30° and a large number of gas detectors (approximately 300). The X-ray tube and detectors rotate continuously about the patient without any linear motion. These systems scan one section in approximately 5 seconds. There are obvious clinical advantages to this scanning time. However, there are disadvantages in the potential for creating artifacts and the need for more carefully synchronizing the detector array. A further refinement consists of a stationary

ring of approximately 600 detectors with only the X-ray tube rotating about the patient.

The second major component, of course, is the computer. Assume that a very narrow X-ray beam traverses an individual at a specific point. A portion of that X-ray beam is attenuated and a portion of it passes through the individual and then impinges upon a detector which converts the energy ultimately to an electrical impulse. A known amount of X-ray energy is therefore sent out. A detectable amount is recorded and the difference between the two is an absorbed dose. The data obtained by this method for a specific core of tissue gives a "profile" of the attenuation of X-rays in the tissue traversed. Each point is ultimately "looked at" from 180 different angles. These profiles then provide the necessary information to reconstruct by an appropriate algorithm, *i.e.*, "filtered back projection," the attenuation coefficient for each point within an object studied. The electrical information is recorded in a digital format by a computer. A line printer can then produce a numerical printout of the absorption coefficient for each picture element that has been reconstructed. In a clinical setting, however, this information is converted into an analog optical image which is viewed on a television monitor and then photographed.

The third major component of a CT system is the console where the operator can communicate with the computers and X-ray units and where the reconstructed image appears on the television screen for viewing.

The X-ray attenuation characteristics of tissues have been set such that water is 0 Hounsfield units, dense bone is +1,000 Hounsfield units and air is -1,000 Hounsfield units. A shade of gray, or for that matter a color, can be assigned to a range of Hounsfield units such that the viewed image is a recognizable anatomic cross-section.

Specific Utilizations

Obviously, in the central nervous system the use of computed tomography is well established. I think that most physicians would agree that few medical instruments have revolutionized the practice of a subspecialty of medicine, namely the neurologic sciences, as has the CT head unit. I would like to concentrate however, on the use of CT in the thorax, abdomen, and pelvis.

The first illustration is through the midthorax. (Fig. 1) I think that you can readily appreciate

the heart and pulmonary vascularity. At the present time with 2 second to 18 second scanners, studies of the heart are not possible. Extremely fast scanners, however, gated to the ECG, are being developed.

There are several indications for computed tomography of the mediastinum. (1) Not infrequently, a lesion may be partially hidden by the mediastinum. This is particularly true in the left lower lobe. Computed tomography gives a clear demonstration of these lesions without superimposed normal structures. (2) Differentiation of a large pulmonary vascular structure from hilar lymphadenopathy particularly by using contrast enhancement. (3) Staging of mediastinal tumors. Subcarinal lymph nodes are particularly well visualized when they enlarge and encroach on the azygoesophageal recess. Pariesophageal and internal mammary lymph nodes are also well seen. (4) Characterization of mediastinal lesions (Fig. 2) by their attenuation coefficient. This is particularly helpful in diagnosing lesions containing fat such as a prominent pericardial fat pad. Thoracic aortic aneurysms and aortic dissections also lend themselves to identification by computed tomography. (5) Computed tomography's cross-sectional approach allows for a different viewpoint of a questionably abnormal mediastinum. This is particularly helpful where a mediastinal contour is equivocal and standard radiography is unable to sort out tortuous or dilated great vessels from normal mediastinal structures. (6) Evaluation of previously nonvisible structures. The diaphragmatic crura are well seen in computed tomography. Abnormalities such as hematomas and enlarged lymph nodes in this area can also be evaluated.

In the pulmonary parenchyma, the major contribution of computed tomography is in the detection of otherwise occult pulmonary nodules. CT has proven to be most useful in diagnosing nodules located just beneath the pleura, adjacent to the heart or mediastinum, and the costophrenic angles. Initial experience indicates that computed tomography detects more nodules than either chest radiography or conventional whole lung tomography. Computed body tomography should be utilized for complete evaluation in those patients whose specific therapeutic modality is to be chosen based on the presence or absence of pulmonary metastases. In addition, where a parenchymal resection is contemplated based on the presence of a single nodule, CT may detect further metastatic deposits.

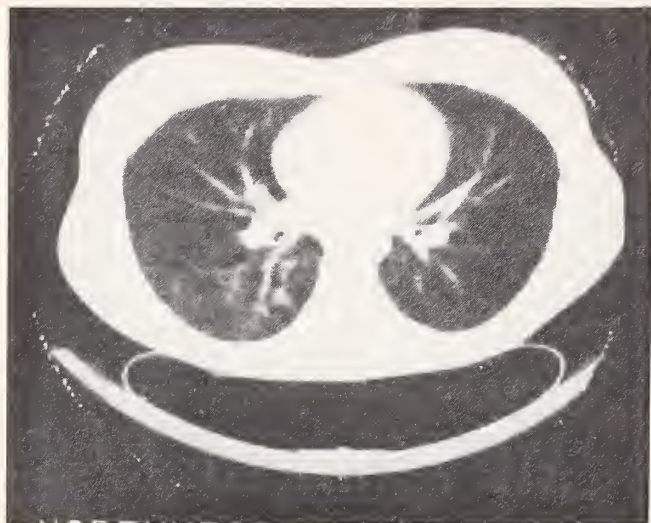


Fig. 1

Note the heart and pulmonary vascularity. At this window level and width mediastinal detail is not obtained.

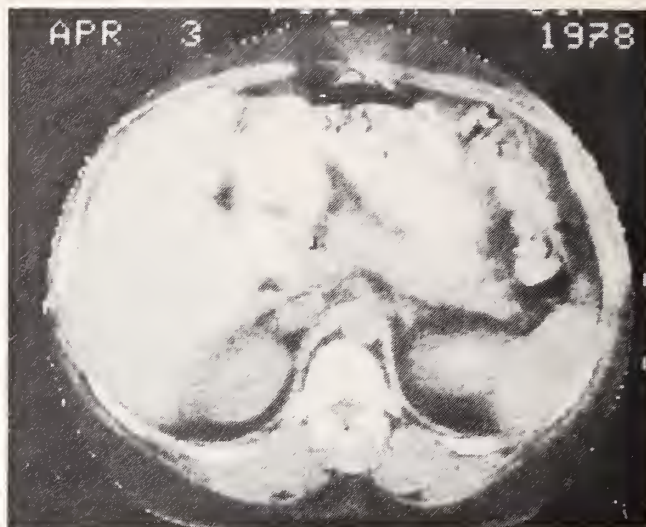


Fig. 2

Normal upper abdomen—not the excellent visualization of the body and tail of the pancreas (arrow-heads), the aorta (arrow), and adjacent inferior vena cava are well seen. The superior mesenteric artery is seen as a grey dot just ventral to the aorta.

Abdominal Examination

At this time, computed tomography appears to show some of the most exciting possibilities in the abdomen. It appears to nicely complement presently available imaging modalities. It has outstanding potential in staging of intra-abdominal masses as it exquisitely defines tissue planes. Obesity and intestinal gas are not a problem and therefore the technique is useful in those individuals where ultrasound fails. By convention, CT scans in the abdomen are displayed as though one is viewing the transected specimen from the feet towards the head. In a supine scan therefore, the patient's left is on the viewer's right (Fig. 2).

The pancreas lies in the upper abdomen with the head adjacent to the second portion of the duodenum. The duodenal sweep is displayed by having the patient ingest oral iodinated contrast material. The uncinata process is seen just posterior to the superior mesenteric vessels. The body of the pancreas is located ventral to the superior mesenteric artery. The splenic vein lies dorsal to the body and tail of the pancreas. The pancreatic tail may be variable in its location, but usually lies close to the hilum of the spleen. The peripancreatic fat, which is of a lower CT density than the pancreas, aids in visualization of this organ. The diagnosis of carcinoma of the pancreas is based on the

presence of a localized mass, alteration in the uniform tapering of the pancreas, obliteration of the posterior peripancreatic fat plane, and an indistinct pancreatic margin. Obviously, the presence of secondary signs of a mass are also quite helpful; dilation of the biliary ducts or pancreatic duct, distension of the gallbladder, or presence of liver metastasis.

Acute pancreatitis tends to have diffuse involvement and slightly decreased density of the gland. If the disease process is focal, however, the appearance is similar to carcinoma. The clinical information should aid in differentiation. The minute calcifications of chronic pancreatitis are easily seen. Pancreatic pseudocysts are easily detected by CT with the pseudocyst having a decreased attenuation coefficient (Fig. 3). Early studies indicate that computed tomographic scanning of the pancreas has an accuracy in the range of 85%.

Liver Scans

The normal liver appears as a homogenous structure that has a higher density than that of the other intra-abdominal organs. Within the liver, linear branching structures are present which represent the intrahepatic vascularity, particularly the portal vein and its branches. Normal intrahepatic biliary radicals are not visible.

Solitary masses from hepatocellular carcinoma,



Fig. 3

The low attenuation of the fluid within a pancreatic pseudocyst (arrow) allows for a high degree of sensitivity in detection of this entity.

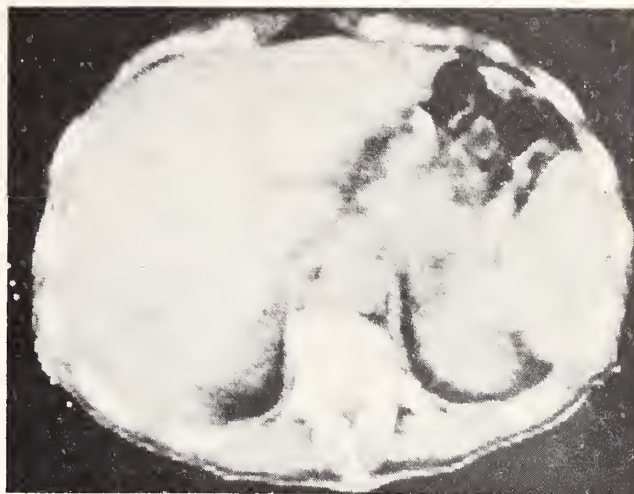


Fig. 4

Marked inhomogeneity of the liver is indicative of diffuse metastatic involvement. Compare the appearance of the liver with that in Fig. 3.

or metastasis are readily detected. Similarly, multiple defects within the liver from metastatic disease can be seen with a high degree of sensitivity. Primary and metastatic neoplasms within the liver appear as focal areas of slightly diminished density. (Fig. 4) Most are well margined, although some have an indistinct margin with the remaining portion of the liver. Injection of iodinated contrast material frequently accentuates the liver-tumor interface and makes detection easier. Other space occupying lesions such as abscesses, cysts, and hematomas can also be detected by computed tomography and their attenuation coefficient suggests a specific diagnosis.

Computed tomography is able to detect variations in size or shape of the liver but otherwise cirrhosis cannot be diagnosed by this method. The exception is the fatty infiltration stage of cirrhosis when the liver has a diminished attenuation. Ascites is easily seen and CT serves therefore, as an adjunctive means of diagnosis in equivocal cases. Dilated intraphepatic biliary radicals, as well as a dilated common bile duct, can be detected by CT. The method is of obvious value in the differentiation of obstructive from nonobstructive jaundice. The accuracy of diagnosis in this setting is approximately 90%.

Uses in Kidney Disease

The kidney is another area where CT scanning has proved to be very useful. CT complements other imaging techniques in the workup

of a renal mass. It is particularly useful in those cases where the diagnosis by ultrasound is equivocal or where the lesion cannot be seen because of technical factors. Solitary masses within the kidney can be easily detected by computed tomography and the nature of the mass lesion specified. Additionally, CT can aid in the pre-operative staging of renal cell carcinoma. The presence of periaortic adenopathy, liver metastasis, and renal vein involvement can all be suggested. Cystic lesions within the kidney present as a characteristic finding with an attenuation coefficient in the range of water. CT frequently demonstrates multiple cystic lesions when previous studies have demonstrated only a solitary cyst and similarly, the presence of an unsuspected renal mass is occasionally noted in a patient being scanned for a different clinical indication.

The presence of hydronephrosis can also be detected in the patient with nonfunctioning kidneys and nonvisualization on routine radiographic studies. Perinephric masses, such as hematoma and abscess can be diagnosed with a high degree of accuracy.

The adrenal gland can be visualized consistently and CT scanning is probably the non-invasive imaging technique for this organ. The technique should prove highly accurate for the diagnosis of pheochromocytoma and adrenal carcinoma. The accuracy in patients with adrenal adenoma and hyperplasia has not yet been determined.

Computed tomography has made a significant contribution in the detection of periaortic adenopathy, particularly in evaluating lymph node enlargement as seen with Hodgkin's disease and non-Hodgkin's lymphoma. It is less accurate in those neoplasms where the metastatic deposits do not enlarge lymph nodes; in these situations, lymphangiography better delineates nodal architecture. CT also provides a convenient and accurate means for follow up in patients with lymphoma following therapy.

The accuracy of CT in evaluating the presence of lymphoma in the spleen, liver, and mesenteric lymph nodes is unknown. Retroperitoneal hemorrhage, abscess and primary tumors can also be detected with a very high degree of accuracy. Intra-abdominal abscesses such as subphrenic and subhepatic lesions additionally, can be studied with computed tomography.

Although ultrasound is the primary imaging modality in the female pelvis, it does have certain limitations and therefore computed tomography is of value in the evaluation of both the female and male pelvis. Specifically, CT is able to define rather exactly, normal tissue

planes and in particular, the pelvic side walls. CT aids in the staging of bladder tumors and that spread of neoplasm beyond the bladder wall is easily seen. Staging of the lesion with CT has obvious implications in the planning of a radiation therapy field. The position of the ureters with respect to a pelvic mass can also be determined following the administration of intravenous contrast material.

Although the uterus and ovaries can be visualized by CT, this procedure remains adjunctive to ultrasound with respect to imaging these structures. Similarly the prostate can be visualized by both modalities, but probably ultrasound remains the imaging technique of choice.

There are numerous other anatomic areas where CT has tremendous potential. For example, we are presently evaluating computed tomography in staging laryngeal neoplasms. Involvement of cartilagenous structures and subglottic extension should be detectable. Abnormalities of the spine, particularly spinal stenosis, can be diagnosed by CT and this cross-sectional approach gives a new dimension to imaging techniques. ◀

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Report on the 1978 AMA-RPS Annual Meeting

BY LINDA L. HUGHEY, M.D./WILMETTE

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

The AMA-RPS meeting in St. Louis was attended by 76 residents; 66 were official delegates. Illinois had six delegates of its allotted eleven. Any Illinois resident & member of the AMA in attendance would have been eligible for delegate status.

Twenty three states were represented as follows: Alabama (2), Arizona (4), California (5), Colorado (2), Connecticut (1), Florida (6), Illinois (6), Indiana (3), Iowa (1), Massachusetts (1), Michigan (3), Minnesota (4), Nebraska (2), New York (1), North Carolina (1), Pennsylvania (7), South Carolina (3), Tennessee (1), Texas (13), Virginia (1), Washington (2), Washington, D.C. (1), W. Virginia (1), Wisconsin (4), Canal Zone (1).

Residents hailed from a wide variety of specialty programs: Family Medicine (11), Internal Medicine (9), General Surgery, OB/GYN (5), Emergency Medicine, Psychiatry & Radiology (4), Anesthesia & Orthopedic Surgery (3), Neurologic Surgery, Neurology, Pathology (2), & one resident each from Allergy, Dermatology, Otolaryngology, & Social Pediatrics. Obviously a wide range of specialties was represented, but an even wider geographic distribution is needed.

The convention included workshops on the impaired physician, cost containment, teaching skills, & organizational skills. After evening receptions & visits with state delegations, the residents scattered all over the city of St. Louis to sample night life under the Silver Arch.

The following Illinois residents attended as delegates:

James DeBord, University of Illinois;
Linda Hughey, University of Chicago;
Ira Isaacson, Northwestern University;
Benjamin LeCompte III, Rush-Pres. St. Luke's;
James McCreary, University of Illinois and
Alan M. Sadov, Rush-Pres St. Luke's

Illinois will be well represented on the Governing Council in the coming year. Dr. DeBord sits on the AMA Council on Scientific Affairs. Dr. Hughey was elected Secretary-Editor of the national AMA/RPS.

The majority of the RPS delegates had *never* attended an AMA convention before. That is the nature of the RPS—a young, rapidly changing group with a lot of room for new ideas and new faces. The Illinois RPS is seeking people interested in involvement at both state & national levels. If interested, you may contact Ira Isaacson, who is chairman of the Illinois RPS, at the ISMS office.

Attending a convention guarantees that you will at least meet interesting people, learn a bit about the politics of health care delivery, and find that residents share many common concerns. At most you may even walk away with a national office or some solutions to those shared problems. We shall look forward to hearing from you.

A Call for Newsbits

Does your housestaff have any projects, problems, or headaches that might be of general interest? Please drop a note to Dr. Linda Hughey via the ISMS at 55 E. Monroe, Chicago, IL 60603. Resident activities may be publicized in this column. Furthermore, we may be able to help with problems either through the ISMS or AMA services to members. Please keep us posted, and we shall try in turn to keep you posted on useful events & services.

Growth Patterns

National Convention Scenes



MRS. EARL V. KLAREN, PRESIDENT, ISMSA

These photos tell the story of a productive national convention in St. Louis in June. I hope they'll also bring a reminder to attend our own Fall Conference, September 19, 1978, at the Sheraton Northbrook Hotel. Fall Conference for the northern counties will center on "The Family in Question: Can It Survive?" An excellent roster of speakers will provoke your interest—and perhaps some solutions.



Illinois Tops in Nation in AMA-ERF Contributions

Mrs. Selig Hodes, (L) AMA-ERF State Chairman, and Mrs. Karl Reddies, Co-chairman, proudly display the achievement award they received during the National Convention in St. Louis. Illinois topped all other states in total contribution to American Medical Association Education and Research Foundation.

This is the fourth year that Illinois has won top honors. The Auxiliary appreciates the terrific cooperation and contributions of the Illinois State Medical Society in this project.

Presidents Past—Present—and Future

(L-R) Mrs. Edward Szewczyk, immediate past president of ISMSA; Mrs. Earl Klaren, 1978-79 president; and Mrs. R. S. Hoover, president-elect, paused for this picture during the Illinois State Breakfast in St. Louis during the AMA Convention.



Several of the delegates, alternates and members attending the AMA Auxiliary Convention in St. Louis June 18-21 were (left to right), Front row: Mrs. William Hodges, Mrs. Edward Szewczyk, past president; Mrs. Earl Klaren, ISMSA president, Mrs. Selig Hodes, Mrs. Karl Reddies. Second row: Mrs. Eugene Leonard, Mrs. Willard Scrivner, Mrs. Harlan English, Mrs. Wendell Roller, Mrs. Eugene Vickery. Standing (3rd row): Mrs. Henry Schorr, Mrs. August Martinucci, Mrs. Frank Holman, and Mrs. Norman Taylor.



**Ogle County Auxiliary
Wins Regional Award
At National Convention**

Mrs. Don Hinderliter, president of Ogle County Medical Auxiliary and newly elected 2nd Vice President of ISMS Auxiliary, was in St. Louis to receive her county's AMA-ERF award. Ogle County has nine members and they worked very hard to raise \$212.00 per member for AMA-ERF. They were North Central's highest contributor and ranked second in the whole United States. Ogle is one of our newest counties, organized in 1975, and we're all very proud of them!

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How to Swim With Sharks: A Primer

Actually, nobody wants to swim with sharks. It is not an acknowledged sport, and it is neither enjoyable nor exhilarating. These instructions are written primarily for the benefit of those who, by virtue of their occupation, find they must swim and find that the water is infested with sharks.

It is of obvious importance to learn that the waters are shark infested before commencing to swim. It is safe to assume that this initial determination has already been made. If the waters were clearly not shark infested, this would be of little interest or value. If the waters were shark infested, the naive swimmer is by now probably beyond help; at the very least he has doubtless lost any interest in learning how to swim with sharks.

Finally, swimming with sharks is like any other skill: it cannot be learned from books alone; the novice must practice in order to develop the skill. The following rules simply set forth the fundamental principles which, if followed, will make it possible to survive while becoming expert through practice.

Rules

1. *Assume unidentified fish are sharks.*—Not all sharks look like sharks, and some fish which are not sharks sometimes act like sharks. Unless you have witnessed docile behavior in their presence or shed blood on more than one occasion, it is best to assume an unknown species is a shark. Inexperienced swimmers have been badly mangled by assuming that docile behavior in the absence of blood indicates that the fish is not a shark.

2. *Do not bleed.*—It is a cardinal principle that if you are injured either by accident or by intent you must not bleed. Experience shows that bleeding prompts an even more aggressive attack and will often provoke the participation of sharks which are uninvolved or, as noted above, are usually docile.

Admittedly, it is difficult not to bleed when in-

jured. Indeed, at first this may seem impossible. Diligent practice, however, will permit the experienced swimmer to sustain a serious laceration without bleeding and without even exhibiting any loss of composure. This hemostatic reflex can in part be conditioned, but there may be constitutional aspects as well. Those who cannot learn to control their bleeding should not attempt to swim with sharks, for the peril is too great.

The control of bleeding has a positive protective element for the swimmer. The shark will be confused as to whether or not his attack has injured you, and confusion is to the swimmer's advantage. On the other hand, the shark may know he has injured you and be puzzled as to why you do not bleed or show distress. This also has a profound effect on sharks. They begin questioning their own potency or, alternatively, believe the swimmer to have supernatural powers.

3. *Counter any aggression promptly.*—Sharks rarely attack a swimmer without warning. Usually there is some tentative, exploratory aggressive action. It is important that the swimmer recognizes that this behavior is a prelude to an attack and takes prompt and vigorous remedial action. The appropriate countermove is a sharp blow to the nose. Almost invariably this will prevent a full-scale attack, for it makes it clear that you understand the shark's intentions and are prepared to use whatever force is necessary to repel his aggressive actions.

Some swimmers mistakenly believe that an ingratiating attitude will dispell an attack under these circumstances. This is not correct: such a response provokes a shark attack. Those who hold this erroneous view can usually be identified by their missing limb.

4. *Get out if someone is bleeding.*—If a swimmer (or shark) has been injured and is bleeding, get out of the water promptly. The presence of blood and the thrashing of water will elicit aggressive behavior even in the most docile of sharks. This latter group, poorly skilled in at-

tacking, often behaves irrationally and may attack uninvolved swimmers or sharks. Some are so inept that in the confusion they injure themselves.

No useful purpose is served in attempting to rescue the injured swimmer. He either will or will not survive the attack, and your intervention cannot protect him once blood has been shed. Those who survive such an attack rarely venture to swim with sharks again, an attitude which is readily understandable.

The lack of effective countermeasures to a fully developed shark attack emphasizes the importance of the earlier rules.

5. *Use anticipatory retaliation.*—A constant danger to the skilled swimmer is that the sharks will forget that he is skilled and may attack in error. Some sharks have notoriously poor memories in this regard. This memory loss can be prevented by a program of anticipatory retaliation. The skilled swimmer should engage in these activities periodically, and the periods should be less than the memory span of the shark. Thus, it is not possible to state fixed intervals. The procedure may need to be repeated frequently with forgetful sharks and need be done only once for sharks with total recall.

The procedure is essentially the same as described under rule three—a sharp blow to the nose. Here, however, the blow is unexpected and serves to remind the shark that you are both alert and unafraid. Swimmers should take care not to injure the shark and draw blood during this exercise for two reasons: First, sharks often bleed profusely, and this leads to the chaotic situation described under rule four. Second, if swimmers act in this fashion it may not be possible to distinguish swimmers from sharks. Indeed, renegade swimmers are far worse than sharks, for none of the rules or measures described here is effective in controlling their aggressive behavior.

6. *Disorganize an organized attack.*—Usually sharks are sufficiently self-centered that they do

not act in concert against a swimmer. This lack of organization greatly reduces the risk of swimming among sharks. However, upon occasion the sharks may launch a coordinated attack upon a swimmer or even upon one of their number. While the latter event is of no particular concern to a swimmer, it is essential that one know how to handle an organized shark attack directed against a swimmer.

The proper strategy is diversion. Sharks can be diverted from their organized attack in one of two ways. First, sharks as a group are especially prone to internal discussion. An experienced swimmer can divert an organized attack by introducing something, often something minor or trivial, which sets the sharks to fighting among themselves. Usually by the time the internal conflict is settled the sharks cannot even recall what they were setting about to do, much less get organized to do it.

A second mechanism of diversion is to introduce something which so enrages the members of the group that they begin to lash out in all directions, even attacking inanimate objects in their fury.

What should be introduced? Unfortunately, different things prompt internal dissension or blind fury in different groups of sharks. Here one must be experienced in dealing with a given group of sharks, for what enrages one group will pass unnoted by another.

It is scarcely necessary to state that it is unethical for a swimmer under attack by a group of sharks to counter the attack by diverting them to another swimmer. It is, however, common to see this done by novice swimmers and by sharks when they fall under a concerted attack.

X

“How to Swim with Sharks,” came into the *Journal* offices anonymously, with a single note reading “Perspectives in Biology and Medicine, Summer, 1973.” If our readers have knowledge of authorship, the information will be gladly acknowledged, and credit given in a forthcoming issue.

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Fully accredited 1400 bed County chronic disease and rehabilitation facility affiliated with two medical schools is seeking a full time chairman, Department of Internal Medicine.

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Viewbox

(Continued from page 67)

Diagnosis: Bronchogenic carcinoma of left upper lung.

Figures 1 and 2 were read in the emergency room as normal. Indeed, there is no fracture or dislocation present. There is, however, a large radiodensity occupying most of the visible lung field. This mass is present on both internal and external rotation films. The patient was called back to the hospital on the following day and chest film (Figure 3) showed a huge left lung mass. This proved to be a bronchogenic carcinoma and was responsible for the patient's symptoms.

The moral to this story is to avoid focusing (either mentally or visually) solely on your original suspicions. Because shoulder films were ordered, the original film reader looked only at the bones. She saw no fracture or dislocation and so interpreted the films as normal. The large mass was missed not because it is a subtle or difficult finding, but because no one directed attention away from their primary consideration. Examine *ALL* of the film. It just takes an extra few seconds.

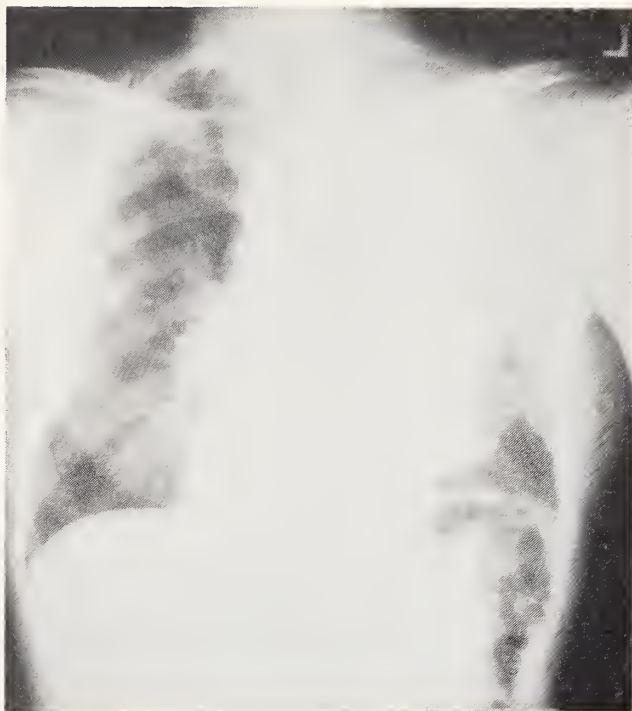


Figure 3

Bronchogenic carcinoma occupying left upper lung.

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IMPAC

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street
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312/782-1963

Dear Doctor:

A recently released Washington survey indicated that in the next four years, physicians will become the most politically powerful group in the county. This was attributed to three factors:

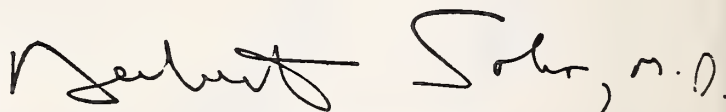
- 1) *physicians are thought to be creditable;*
- 2) *physicians are united in their efforts; and*
- 3) *physicians are willing to use their time and money to support causes they are interested in.*

As Chairman of the Illinois Medical Political Action Committee, I find this survey particularly interesting since half of the physicians in Illinois have not taken the easiest step in achieving a goal to which we, as citizens and physicians, must be committed -- good government. Fifty percent of my fellow physicians have not yet joined IMPAC.

In these days of double-digit inflation and ever-increasing government regulation of our lives, no single item can be higher on our priority list than electing top quality people to government service. IMPAC is committed to this goal and you can help by joining. Mail your check to: IMPAC, 55 East Monroe Street, Suite 3510, Chicago, Illinois 60603.

Remember, IMPAC is scrupulously non-partisan. We contribute to good candidates without regard for political party affiliation.

Won't you join us in this important activity?



Herbert Sohn, M.D.
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

Doctor's News

IPS TO HOLD FIFTH ANNUAL FALL WEEKEND MEETING—The Illinois Psychiatric Society will hold its Fifth Annual Fall Weekend Meeting from October 6-8, at the Chicago Hyatt Regency O'Hare.

Jerome S. Beigler, M.D., president and Melvin Prosen, program chairman, have announced that the three-day session will feature symposia, workshops, lectures and film presentations on a variety of clinical and socio-economic issues. Those who participate in the entire program will be entitled to receive 14 hours of AMA Category 1 CME credit.

For further information, please contact Wendy J. Smith at the Society's offices, 55 East Monroe, Suite 3510, Chicago 60603 (312-782-1654).

INTERSTATE SCIENTIFIC ASSEMBLY ANNOUNCED—The 63rd Annual International Scientific Assembly of the Interstate Postgraduate Medical Association is scheduled for October 23-26 at the Washington Hilton Hotel in Washington, D.C. The program of clinical discussion and instruction is designed for primary care physicians practicing in the U.S. and Canada. For further information, please contact Alton Ochsner, M.D., program chairman, Interstate Postgraduate Medical Association, P.O. Box 1109, Madison, WI 53701.

LAST INTRAV TRIP FOR 1978—One of the ISMS travel programs for 1978 remains open for reservations. Persons interested in the West Indies Air/Sea Christmas Cruise scheduled for December 19-27, 1978, should contact the ISMS headquarters as soon as possible. Information on 1979 programs will be available in the near future.

DEATH AWARENESS CONSORTIUM ANNOUNCED—The Illinois Funeral Directors Association will sponsor a special program for health care professionals on September 20, from 9:30 a.m. to 4:30 p.m., in the Chicago Room at McCormick Place. The program, which is co-sponsored by ISMS, will feature speakers on coping with sudden death and mourning, a wholistic approach to grief and health care and several other topics. Interested persons should contact the Illinois Funeral Directors Association, 1045 Outer Park Drive, Suite 120, Springfield, 62704. A self-addressed, stamped envelope with prepayment is requested. The registration fee is \$12.00, and \$18.00 for both the seminar and luncheon.

I QUIT SMOKING CLINICS—The Illinois Interagency Council on Smoking and Disease and the American Cancer Society will sponsor a series of clinics in coming months. Clinics are also scheduled in cooperation with the Chicago Department of Health, and several will be held in Chicago suburbs and Rockford. For further information, contact the Illinois Interagency Council on Smoking and Disease, 20 N. Wacker Drive, Room 1240, Chicago 60606 (312-346-4675).

SNAKE-BITE CENTER—The Antivenin Committee of the American Association of Zoological Parks and Aquariums has announced that a 24-hour Antivenin Index Center is available to physicians seeking antidotes for snakebites. The center maintains a catalog of snake-bite antivenins stocked in North American zoos, laboratories and related institutions. They can inform treating physicians of the nearest sources and make arrangements for emergency delivery. Physicians who encounter this problem are asked to determine the scientific and vernacular name of the snake involved, and call 405-271-5454 to obtain the necessary information.

CALL FOR ABSTRACTS—The American College of Chest Physicians invites abstracts for the International Conference on Occupational Lung Disease, which will be held February 27-March 2, 1979, at the Hyatt Regency-Embarcadero in San Francisco. Papers on all aspects, including particle deposition, lung defenses, epidemiology and pathology are requested. They should not exceed 600 words in length and must be received by September 11, 1978. For further information, please write: Chairman, Scientific Program Committee, International Conference on Occupational Lung Disease, c/o ACCP, 911 Busse Highway, Park Ridge, IL 60068.

PHYSICIANS IN THE NEWS—Clifton L. Reeder, M.D., Park Ridge, was installed as 1978-79 president of the Chicago Medical Society. Doctor Reeder is the chief executive officer and medical director of Bodimetric Profiles Division, American Service, Chicago, and also medical director and director of Bodimetric Profiles, Canada, Ltd.

The Chicago Medical Society also announced that Lawrence L. Hirsch, M.D., Chicago, is their new president-elect. Doctor Hirsch, a member of the ISMS Board of Trustees and chairman of the Policy Committee, is the former chairman of the ISMS Publications Committee and current chairman of the department of family medicine at the Chicago Medical School. Robert C. Hamilton, M.D., Chicago, was named chairman of the CMS Council, and Finley W. Brown, Jr., M.D., was elected vice chairman. Franklin Lounsbury, M.D., River Forest and John P. Harrod, Jr., M.D., Chicago, were renamed to their respective posts as secretary and treasurer of the Society.

Bertram B. Moss, M.D., Chicago, has been named co-director of the Illinois Masonic Medical Center Family Practice Center in Chicago. Doctor Moss, former director of the St. Joseph Hospital Family Health Center, was also appointed an adjunct associate professor of aging health care services for the UI School of Public Health. . . . The University of Illinois House Staff Association has elected new officers. James McCreary, M.D., Cicero, was elected president, Lawrence Pankau, M.D., Chicago, vice president and Mary Louise Kaminski, M.D., Chicago, secretary-treasurer of the 460-member association.

The Chicago Laryngological and Otological Society has elected George A. Sisson, M.D., Chicago to serve as their 1978-79 president. William M. Gatti, M.D., Bannockburn and Jack D. Clemis, M.D., Wilmette, were elected vice president and secretary-treasurer respectively.

The medical staff at Jackson Park Hospital has elected Leonard I. Silverman, M.D., Chicago, to serve as their new president. . . . The citizens of Chicago's twelfth congressional district have chosen Gilbert Bogen, M.D., a Chicago psychiatrist, to oppose republican incumbent U.S. Rep. Philip M. Crane in the November elections. . . . New officers of the Chicago Gynecological Society are: Robert E. Lane, M.D., Northbrook, president, Herman A. Strauss, M.D., Chicago vice president, Michael P. MacLverty, M.D., Chicago, president-elect, Uwe W. Freese, M.D., Chicago, treasurer, Antonio Scommegna, M.D., Chicago, secretary and Holden K. Farrar, Jr., M.D., Winnetka, assistant secretary.

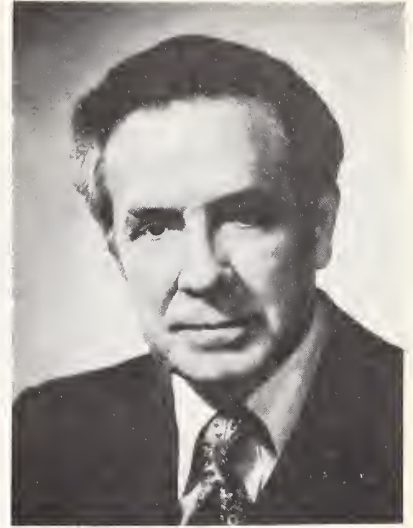
RESOLUTIONS DEADLINE—Proposed resolutions for the Interim Meeting of the ISMS House of Delegates must be postmarked no later than September 2, 1978, in order to be published in the *IMJ*. In accordance with a resolution passed at the 1978 Annual Meeting resolutions will be published in the Journal by author and subject *only*.

The final deadline for resolutions for the 1978 Interim meeting is October 7, 1978. Resolutions received after that date will be considered late resolutions and require special action for possible consideration.

President's Page



The Illinois Voluntary Effort



The Voluntary Effort (VE) to check the health cost spiral appears to be working.

Statistics released last month reveal that hospital costs rose at the equivalent of a 12.7% annual rate during the first four months of this year—down from a nearly 16% rate last year. In April, the 11.3% annualized rate of increase was the lowest of any month since 1974. While these figures are encouraging, they represent only a short-term decrease that will be increasingly difficult to hold and improve upon over the long run.

The goal of the VE—launched last November by AMA, AHA and Federation of American Hospitals—was to reduce hospital rate increases by 2% both this year and next. Its success thus far is largely attributable to the program's growing momentum at the state level.

Illinois is a good example. ISMS and the Illinois Hospital Association have united their cost containment programs and formed a steering committee to direct the VE in Illinois. In addition, the ISMS Task Force on Cost Effectiveness is continuing its activities and will serve as a valuable resource body for the steering committee. This type of cooperation within the health care "industry" serves to deflate the Carter Administration's charge that the VE is merely a charade to stall implementation of federal controls.

Obviously, the VE now must be viewed as a positive commitment. Nonetheless, the Administration's attempted power grab continues along with a move to undermine our initiatives. A classic example was the Justice Department's recent refusal—at the urging of HEW—to grant anti-trust exemptions to the VE.

If the Administration succeeds in ramming a mandatory hospital cost containment bill through Congress, it is reasonable to assume that physicians' fees will be the next target. Newly-installed AMA President Dr. Thomas Nesbitt acknowledged that possibility when he urged physicians to cut the rate of fee increases by one percent for each of the next two years. That formula—which parallels the VE goal—would bring the rate of fee escalation close to the "all items" rate of the Consumer Price Index.

The Administration has not yet convinced Congress that federal cost controls are needed. However, the Congressional viewpoint could radically change if year-end totals for the VE fall short of target.

The private sector of the health care system has made significant progress toward a solution to the cost problem. However, the ultimate success of this effort—and the future of our system—depends upon the combined efforts of each hospital and you, the practicing physicians.

David S. Fox, M.D., President

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EKG

(Continued from page 63)

Answers: 1. B & C 2. E

The electrocardiogram shows a tachycardia with a wide QRS complex. The QRS duration is approximately 0.14 seconds and the rate is 136 beats per minute. The black marks in lead II mark out P waves which indicate atrioventricular dissociation. This plus the wide based QRS complex suggests that this is a ventricular tachycardia. The RR cycles are not precisely regular but this is not unusual in ventricular tachycardia. The presence of sinus P waves at a rate of 86 beats per minute rules out atrial fibrillation as a consideration as well as atrial tachycardia. A fascicular ventricular tachycardia would have a normal QRS duration and a QRS contour suggesting incomplete right bundle branch block. This tachycardia is thought to arise in the posterior division of the left bundle branch. The QRS contour of the ventricular tachycardia in this patient resembles left bundle branch block. Therefore, the focus of the ventricular tachycardia is probably in the right ventricle. This patient subsequently underwent cardiac catheterization and coronary angiography to evaluate his cardiac anatomy. The coronary arteriogram showed a totally occluded right coronary artery and a discreet paradoxically contracting posterior left ventricular aneurysm. All of the intracardiac pressures were within normal limits. Surgery did not seem justified on the basis of his cardiac anatomy since the distal right coronary artery was not well visualized and the posterior left ventricular aneurysm was too small. A decision was made to treat the patient with medications utilizing drug levels to maximally tolerated doses. On a combination of Procainamide, 750 mg. Q 6 hours and Disopyramide, 200 mg. Q 6 hours with Lanoxin and Lasix, the tachycardias were controlled. The patient was gradually ambulated and subsequently was discharged from the hospital. He continues to do well without further tachycardias at eight months of follow-up. The prognosis in cases of ventricular tachycardia is related to the severity of the underlying heart disease, that is, congestive heart failure or Digitalis intoxication or the severity of coronary artery disease. In this patient's case, he only had single vessel coronary artery and his left ventricular function in sinus rhythm were normal.

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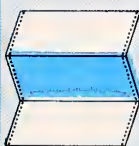
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Along the Track of Education

BY MAGDA BROWN, PUBLICITY CHAIRMAN

The American Association of Medical Assistants—Illinois Society, offers a well-rounded educational day for medical office staff on Sunday, October 1, 1978. The program is scheduled from 8:30 a.m. until 4:00 p.m. at the Ramada Inn, 500 W. River Road, Elgin, Ill. (312-695-3000)

Greetings by Mrs. Leslie Lee, President, AAMA Illinois Society and by Ms. Mary Woolcott, President, Kane County Chapter, will open the days program. The meeting is coordinated by the Kane County Chapter under the direction of Mrs. Phyllis Harwood, CMA-AC.

Thomas R. Harwood, M.D., a pathologist and associate professor at Northwestern University medical and dental schools, will present a talk entitled "On The Track of Better Utilization of the Medical Laboratory." He will consider the purposes of lab. tests, interpretation of results, and utilizing tests in patient care.

Daniel Weiler, Assistant State's Attorney from Kane County and a member of the local, state, and national bar associations will discuss "Physician Liens, Estate Filings, and Closing a Medical Office Upon Death or Retirement of a Physician." He will stress the importance of estate filings, what the medical office assistant

should know regarding them, the procedures to be followed and the rights of patients under these conditions.

"Current Bookkeeping Procedures" by Mr. David Hofer, a certified public accountant and field consultant for Medidentric, Inc., will focus in on bookkeeping methods utilized exclusively in medical offices. These include pegboard systems—both in check writing and daysheet journals, payroll procedures and requirements, quarterly payroll reports, balancing bank statements, and balancing and collection of accounts receivable.

Application has been filed with the American Association of Medical Assistants for consideration of awarding Continuing Education Units for the above listed subjects.

Registration fee includes luncheon. Before September 15th the cost for members is \$10.00, students: \$7.50, and non-members: \$12.50. Late registration fee for members is \$12.50, students: \$10.00, and non-members: \$15.00. Please make check payable to: AAMA, Illinois Society, Personal Development. Mail it with the form below to: Mrs. Phyllis Harwood, 1142 Florimond Dr., Elgin, 60120 (312-742-6804). The registration deadline is September 25, 1978.

please detach

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ACADEMIC DIRECTOR, INTERNAL MEDICINE: University of Illinois affiliated community hospital seeks individual to be responsible for undergraduate, graduate and continuing medical education, and administration of residency and outpatient center. Physician we seek must be American Board of Internal Medicine certified. In return we offer a challenging and rewarding experience plus a competitive salary and benefit program. Send resume in complete confidence to: Box 917, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

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ORTHOPEDIC SURGEON who desires to locate in a rural area of southern Illinois needed to serve two community hospitals. One hour from St. Louis. Good educational system for children. Excellent recreation. Reply: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263.

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ENT SPECIALIST needed in a large, fast growing Chicago suburb. No other ENT specialist in town. Very favorable terms. Send resume to Box 926, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

DERMATOLOGIST needed for a large, fast growing Chicago suburb. Solo practice. Ideal for a second office. Office space available in a new medical complex. Very favorable terms. Send resume to Box 928, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

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MATTOON—CHARLESTON, ILLINOIS. Sara Bush Lincoln Health Center Emergency Department has July opening for qualified physician. Guarantee \$50,000-\$55,000 with ideal working conditions and schedule. Send curriculum vitae to Stephen Allin, M.D., Emergency Department Director, P.O. Box 372, Mattoon, Illinois 61938 or call toll free 1-800-325-3982 for details.

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FAMILY PRACTICE PHYSICIAN who is interested in obstetrics wanted to do primary care. \$42,000 plus fringes (IRS-approved profit sharing plan) to start. Contact H. Osmus, Administrator, Hedges Clinic S.C., 222 Colorado, Frankfort, IL 60423; or (815) 469-2123.

ILLINOIS—PEORIA—Interviewing career Emergency Physicians for full-time openings starting immediately and Jan. 1. Opportunity to join young ACEP oriented physicians' group in 550-bed Medical-Surgical Hospital affiliated with Peoria School of Medicine. Good specialty backup. Flexible scheduling. Superior compensation with liberal fringe benefits including malpractice. Contact H. T. Stratton, M.D.; Methodist Medical Center, 221 NE Monroe, Peoria, IL 61636; (309) 672-4974 or (309) 672-5501.

CHILD PSYCHIATRIST—Full or part time. Modern residential treatment center for children & adolescents. Write or call Jose R. Sanchez, M.D., Medical Director, Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, Ill. 60634. (312) 794-4000.

PEDIATRICIAN—Full or part time. Modern residential treatment center for children & adolescents. Write or call Jose R. Sanchez, M.D., Medical Director, Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, Ill. 60634. (312) 794-4000.

PSYCHIATRIST—Adult Inpatient Services. Full or part time, for modern residential facility. Write or call Jose R. Sanchez, M.D., Medical Director, Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, Ill. 60634. (312) 794-4000.

GENERAL PRACTITIONER, FAMILY PRACTITIONER, needed for rural Illinois town near metropolitan area. Private office, full equipment and established practice available for sale or lease. Write: James R. Hastings, Executor, 301 NW 2nd St., Aledo, Illinois 61231, or telephone (309) 582-5388.

FOR SALE, LEASE OR RENT

MEDICAL OFFICE SUITE FOR RENT, Lincoln-Belmont Bldg. 715-1200 square feet, available at once in full service, elevator, active professional building. Call Gary Solomon, (312) 334-5400.

MEDICAL CENTER FOR RENT. Complete and ready to open. 4300 sq. ft. at 2301 E. 95th Street, Chicago. Large waiting rm., 18 exam rms., x-ray rm., central a/c & heat. Call Gary Solomon, (312) 334-5400.

SUITE TO LEASE for Internist, Pediatrician, Psychologist, Psychiatrist or other medical practice. Suite is located in a high quality building with a growing medical community situated across from a major hospital. The complex already includes an outstanding lab, X-ray facility, pharmacy and 16 professionals. Arrangement provides flexibility for the new tenant to share a suite with an existing practice, to have office built in newly created bare space and to participate in the ownership and direction of the complex. STRONG Property Managers, Ltd. Agents, 201 W. Springfield, Champaign, IL 61820. (217) 356-2617.

SPACIOUS Northside Lakeview area medical office for rent. Newly remodeled. Five examining rooms, carpeted. Large furnished waiting room. Available now. Interested in Spanish speaking doctors only. Growing Spanish speaking area. Near Ashland-Lincoln and Belmont. Pharmacy space also available, if desired. Please contact: Dr. Pedro O. Cabrera (Dentist) at 1442 W. Belmont or call (312) 528-0068.

FOR SALE: 31-year-old established general practice and clinic. Fully equipped and furnished. Clinic and practice can accommodate two doctors. Contact: Bob Billa, 2931 East Southcross Blvd., San Antonio, Texas 78212.

LISLE-MEDICAL SUITE available in prestigious modern building located on Rt. 53 in Lisle. X-ray facilities on premises. Zone controlled heating and air conditioning. Ample parking. Call 969-2850.

FOR SALE: Solo or Group Practice/south western Chicago suburb. Comprehensive Medical Center: Internal Medicine, OB-GYN, Pediatrics, Optometry, Dental, X-ray Equipment, Medical Lab and Pharmacy. 7000 sq. ft., 15 fully equipped examining rooms plus business offices. Private parking. Estimated Annual Gross Income: middle six figures. Negotiable financing. Outstanding opportunity with excellent potential. Please direct inquiries to: Box #933, c/o **ILLINOIS MEDICAL JOURNAL**, 55 E. Monroe, Chicago, IL 60603.

RANCH-STYLE MODERN MEDICAL-DENTAL BUILDING FOR RENT: Customized facilities to meet every medical and dental need. Ideal for family physician or group practice. 1500 to 2500 sq. ft. available. Armitage and Damen area, Chicago. Near St. Mary of Nazareth Hospital. Present physician re-locating leaving well established practice. (312) 472-5126 or 338-9347.

GENERAL PRACTICE FOR SALE: Excellent quality practice including industrial medicine. Northwest Suburban location with community hospital. Sale due to illness — Seller will assist in transition with hospital privileges, employees, etc. Contact Mark Gorman at 3916-67th Street, Kenosha, Wisconsin 53142. 414-654-9166.

SITUATIONS WANTED

DR. P. J. REDDY—Male, 39 years—Psychiatry, M.D., D.P.M., F.R.C.P.(C), ABPN, with total ten years of wide experience in Psychiatry with Illinois license looking for place in private practice or a salaried job.

DR. P. V. REDDY—Female, 34 years—OB-GYN, M.D., M.R.C.O.G. (U.K.), American Board Certified with Illinois license. Total ten years in OB-GYN. Looking for place in private practice or a salaried job. Please contact Dr. P. J. Reddy, Union Hospital, Moose Jaw, Saskatchewan, Canada. Office—(306) 692-1841; Home—(306) 693-3288.

BOARD CERTIFIED RADIOLOGIST, 40, graduate of American medical school available for film reading in office, clinic or home. Daily pick-up service if desired. Excellent references. Please contact Illinois Medical Journal, Box No. 930, 55 East Monroe, Chicago, Illinois 60603.

INTERNIST—29, university trained seeks partnership or group practice opportunity in Chicago area. Available July 1979. Box 929 or phone (312) 280-1156 after 6 pm.

CERTIFIED PHYSICIAN'S ASSISTANT with excellent medical, research and administrative background and experience. Available for Chicago or suburbs. Reply Box 934, c/o Illinois Medical Journal, 55 E. Monroe, Chicago, IL 60603.

MISCELLANEOUS

REAL ESTATE MANAGEMENT: You are a professional but are you a professional landlord? We are Professional Landlords who can manage your property completely so that you can devote full time to your profession. If you own apartment complexes, office buildings or shopping centers, our management skills can reduce your expenses and maximize your cash flow. **COMBINED CAPITAL ASSOC.**, Suite 2015 Tribune Tower, 435 No. Michigan Ave., Chicago, IL 60611. Tel. (312) 337-6655.

GUARANTY FUND CERTIFICATE

GUARANTY FUND CERTIFICATE: Class 8 Inter-Insurance Exchange Certificate for sale (previously class 5). Call 266-1977, 9-5 P.M.

GUARANTY FUND CERTIFICATE for sale at discount. Phone (312) 579-0133.

ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE Guaranty Fund Certificate for sale. Territory 1 Class 1—Purchase price \$772. Best offer. Please contact Mrs. Burton at 388-8052.

GUARANTY FUND CERTIFICATE issued by the Illinois State Medical Inter-Insurance Exchange for sale. Coverage \$100,000/\$300,000. Original purchase price \$6,024.00. Interested call (312) 963-8777 or 920-8792.

GUARANTY FUND CERTIFICATE—Anesthesiologist relocating, Class 5, 1,000,000/1,000,000 coverage. Original price 10,000—purchase price 8000.00 or best offer. Favorable conditions may be arranged. Send inquiries to Box 922, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

GUARANTY FUND CERTIFICATE for sale. This certificate is worth \$3096 toward your purchase of any Class III, IV or V certificate. Will discount price. Call evenings 312-293-1993.

FOR SALE: Illinois Medical Inter-Insurance Exchange Guaranty Fund Certificate, 100,000/300,000, Class 1, Terr. I. Cost 1977, one thousand-thirty two dollars (\$1032.00). Contact: Hans F. Waecker, D.O., 5200 S. Ellis Ave., Chicago 60615.

GUARANTY FUND CERTIFICATE: Wanted to purchase-Guaranty Fund Certificates for the Illinois State Medical Inter Insurance Exchange—call (312) 423-4499.

GUARANTY FUND CERTIFICATE for Territory II, Class 3—amount \$2572.00—for sale. Please contact: V. J. Kelly, M.D., Cisco Lake Road, Watersmeet, MI 49969; (906) 358-4640.

GUARANTY FUND CERTIFICATE for sale. Class 5, Territory II, Original Cost \$4792.00. Coverage: \$100,000/300,000. Asking price: \$3,000, negotiable. Contact Dr. Ignacio A. Chaves, 108 Crass St., Dongola, IL 62926; (618) 827-4488.

GUARANTY FUND CERTIFICATE, No. 214, Illinois State Medical Inter-Insurance Exchange. Contact James R. Hastings, Executor, Estate of James W. Hastings, M.D., 301 NW 2nd Street, Alledo, Illinois 61231. Phone 309-582-5388.

GUARANTY FUND CERTIFICATE for sale: Class 5, territory II for \$1,000,000/\$1,000,000 coverage, purchase price \$6,024.00. For sale for \$4,500.00. For information call (816) 364-5255, or write to Professional Anesthesia Services, Inc., 416 North Seventh, St. Joseph, MO 64501.

IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.

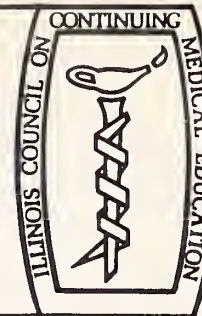
ISMS Travel Program

Only one of the ISMS travel programs scheduled for 1978 remains open for reservations: the West Indies Air/Sea Christmas Cruise (Dec. 19-27, 1978). Information on the 1979 programs will appear in the next issue.

Descriptive brochures will be mailed five months in advance. Reservations cannot be accepted without the official form printed in these brochures. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. *Promotional expenses connected with these programs are paid for by the tour operator.* For further information, contact ISMS headquarters.

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

SEPTEMBER

Anesthesiology

EKG FOR ANESTHESIOLOGISTS

For: Anesthesiologists. Lecture, beginning Sept. 18, Chicago. Speaker: Alon P. Winnie, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$225. Reg. limit: 35. CME Credit: AMA Category 1, 35 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Dermatology

SPECIALTY REVIEW COURSE IN DERMATOLOGY

For: Dermatologists. Lecture, beginning Sept. 25, Chicago. Speaker: Marshall Blankenship, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$225. Reg. limit: 75. CME Credit: AMA Category 1, 35 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Family Practice

ESSENTIALS OF ELECTROCARDIOGRAPHY

For: Family Practitioners. Lecture, beginning Sept. 18, Chicago. Speaker: Kenneth Rosen, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$225. Reg. limit: 50. CME Credit: AAFP Prescribed, 35 hours; AMA Category 1, 35 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Infectious Disease/Urology

21ST MEDICAL/SURGICAL SEMINAR FOR LAKE COUNTY

For: M.D.'s, D.D.S.'s, R.N.'s, Rh.P.'s Seminar, September 20, 8:00 AM-1:00 PM, Waukegan, IL. CME credit: AAFP Elective, 5 hours; AMA Category 1, 5 hours. Reg. deadline: 9/20. Reg. limit: none. Fee: \$2.50, staff; \$5.00, non-staff. Sponsor: St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. Contact: R. M. Adelman. Telephone: 312-688-5800.

Internal Medicine

OBESITY AND DIABETES—A PERPLEXING ODD COUPLE

For: M.D.'s, residents. Lecture, Sept. 27, 11:00 a.m., Auditorium, Martha Washington Hospital, 4055 North Western Ave., Chicago 60618. Cosponsor: Pfizer Laboratories. Speaker: Karl E. Sussman, M.D., Professor of Medicine, University of Colorado, Denver. Reg. deadline: 9/26. Reg. limit: none. Fee: none. CME Credit: AAFP Elective, 1 hour; AMA Category 1, 1 hour. Contact: Fernando Villa, M.D. Phone: 312-583-9000 x 331.

Medical Genetics

2ND ANNUAL SYMPOSIUM ON MEDICAL GENETICS

For: Physicians, nurses, social workers. Symposium, Sept. 15, 8:30-4:30 p.m., Springfield, IL. Fee: \$55. Reg. limit: none. CME Credit: AAFP Elective, 5 hours; AMA Category 1, 5 hours; INA applied for. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

CURRENT TOPICS IN INTERNAL MEDICINE

For: Internists, Family Practitioners. Lecture, beginning September 25, Chicago. Speaker: Sheldon Waldstein, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$225. Reg. limit: 100. CME Credit: AMA Category 1, 40 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Neurology

NEUROLOGY, PART II, CLINICAL

For: Neurologists, Psychiatrists. Lecture, beginning Sept. 11, Chicago. Speaker: Neil Allen, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$250. Reg. limit: 150. CME Credit: AMA Category 1, 44 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Obstetrics & Gynecology

SPECIALTY REVIEW IN OB-GYNE

For: Obstetricians, Gynecologists. Lecture, beginning Sept. 25, Chicago. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$400. Reg. limit: 200. CME Credit: AMA Category 1, 83 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

DEPARTMENTAL MEETING

For: Obstetricians, Gynecologists. Lecture, Sept. 1, 8:00 a.m., Evanston. Sponsor: St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. Reg. limit: none. CME Credit: AMA Category 2, 1 hour. Contact: Mitchel Byrne, M.D. Phone: 312-492-6227.

GYNECOLOGICAL LAPAROSCOPY

For: Gynecologists. 3-day lecture, beginning Sept. 13, Illinois Masonic Hospital, Chicago. Speaker: John Barton, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$300. Reg. limit: 8. CME Credit: AMA Category 1, 18 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

INFECTIONS

For: Gynecologists. Lecture, Sept. 8, 8:00 a.m., St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. Speaker: H. Price, M.D. Sponsor: St. Francis Hospital. CME Credit: AMA Category 2, 1 hour. Contact: Mitchel Byrne, M.D. Phone: 312-492-6227.

GYNECOLOGICAL INFECTIONS AND USE OF ANTIBIOTICS

For: Gynecologists. Lecture, Sept. 15, 8:00 a.m., St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. Speaker: H. Price, M.D. Sponsor: St. Francis Hospital. CME Credit: AMA Category 2, 1 hour. Contact: Mitchel Byrne, M.D. Phone: 312-492-6227.

HIRSUTISM AND ADRENOGENITAL SYNDROME

For: Gynecologists. Lecture, Sept. 22, 8:00 a.m., St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. Speaker: R. Kissel, M.D. Sponsor: St. Francis Hospital. CME Credit: AMA Category 2, 1 hour. Contact: Mitchel Byrne, M.D. Phone: 312-492-6227.

DEPARTMENTAL MEETING

For: Gynecologists. Lecture, Sept. 29, St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. Sponsor: St. Francis Hospital. CME Credit: AMA Category 2, 1 hour. Contact: Mitchel Byrne, M.D. Phone: 312-492-6227.

Orthopedic Surgery, Pathology

A SHORT COURSE ON BONE TUMORS

For: Orthopods, Pathologists. 2½ day course/workshop, Sept. 14-16, Chicago. Sponsor: Rush-Presbyterian-St. Luke's Medical Center, Office of Continuing Education, Academic Facility, 600 S. Paulina St., Chicago 60612. Fee: \$300. Reg. limit: 60. CME Credit: AMA Category 1, 15 hours. Contact: Jeffrey Norman. Phone: 312-942-7095.

Pediatrics

SOLVING DIFFICULT PROBLEMS IN AMBULATORY PEDIATRICS: A MULTIDISCIPLINARY APPROACH

For: Pediatricians. 3-day lecture, Sept. 21-23, The Kellogg Center for Continuing Education, MSU. CME Credit: AMA Category 1, 16 hours. Contact: Conferences and Institutes, 50 Kellogg Center, MSU, East Lansing, Michigan 48824. Phone: 517-355-4588.

Psychiatry

SEXUAL MEDICINE

For: Psychiatrists, Neurologists. Lecture, beginning Sept. 25, Chicago. Speaker: Domeena Renshaw, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood Street, Chicago 60612. Fee: \$250. Reg. limit: 100. CME Credit: AAFP Prescribed, 40 hours; AMA Category 1, 40 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Radiography

QUALITY ASSURANCE EVALUATION OF THE RADIATION DEPARTMENT

For: Radiologists. 3-day lecture, beginning Sept. 14, Chicago. Speaker: Theodore Fields, M.S. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$200. Reg. limit: 75. CME Credit: AMA Category 1, 24 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Surgery

FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY

For: Surgeons, Internists. Lecture, beginning Sept. 18, Chicago. Speaker: C. Thomas Bombeck, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$300. Reg. limit: 15. CME Credit: AMA Category 1, 19 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

FIBEROPTIC COLONOSCOPY

For: Surgeons, Internists, Family Practitioners. 3-day lecture, beginning Sept. 13, Chicago. Speaker: Herand Abcarian, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$300. Reg. limit: 15. CME Credit: AMA Category 1, 19½ hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

TREATMENT OF THE INJURED HAND

For: Surgeons. 1-day course, Sept. 9, Chicago. Sponsor: Rush-Presbyterian-St. Luke's Medical Center, Office of Continuing Education, 600 South Paulina St., Chicago 60612. Fee: resident, \$50; Rush Network physician, \$80; other physician, \$100. CME Credit: AMA Category 1, 7 hours. Contact: Office of Continuing Education. Phone: 312-942-7095.

MICROSURGICAL WORKSHOP

For: Surgeons. 1-day workshop, Sept. 8 or Sept. 10, Chicago. Speaker: Robert Schenck, M.D., Associate Professor and Director, Hand Surgery Section, Sponsor: Rush-Presbyterian-St. Luke's Medical Center, Office of Continuing Education, 600 South Paulina St., Chicago 60612. Fee: \$125. CME Credit: AMA Category 1, 8 hours. Contact: Mrs. Woodfork. Phone: 312-942-7095.

OCTOBER

Allergy

IMMUNOLOGIC INJURY

For: Family Practitioners, Allergists. Lecture, Oct. 18, 2:00 p.m., Itasca Country Club. Speaker: Chester R. Zeiss Jr., M.D., Asst. Professor of Medicine, Northwestern University Medical School. Sponsor: DuPage County Medical Society, 26 W. St. Charles Road, Lombard, IL 60148. Reg. deadline: 10/16. Fee: none. Reg. limit: none. CME Credit: AAFP Elective, 2 hours; AMA Category 1, 2 hours. Contact: Lillian Widmer. Phone: 312-495-4050.

Biomed

FOURTH ANNUAL MEDICAL PHOTOGRAPHY WORKSHOP

For: all physicians. 1-day symposium/workshop, October 28, Springfield, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. CME Credit: AAFP Elective, 6 hours; AMA Category 1, 6 hours. Reg. limit: none. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Diabetes

RECENT ADVANCES IN DIABETES

For: residents and attending staff. Lecture, October 25, 11:00 a.m. (lunch follows), Martha Washington Hospital, 4055 N. Western, Chicago, IL 60618. Speaker: Arthur H. Rubenstein, M.D., Professor and Associate Chairman, Dept. of Medicine, The University of Chicago. CME Credit: AAFP Elective, 1 hour; AMA Category 1, 1 hour. Fee: none. Reg. limit: none. Reg. deadline: 10/24. Sponsor: Martha Washington Hospital. Contact: Fernando Villa, M.D. Phone: 312-583-9000 x 331.

Internal Medicine, Family Practice, Pediatrics

CLINICAL ALLERGY FOR PRACTICING PHYSICIANS
For: Physicians. 3-day symposium, October 5-7, St. Louis, MO. Sponsor: Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. CME Credit: AAFP Elective, 16 hours; AMA Category 1, 16 hours; AOA, 16 hours. Fee: \$150. Reg. limit: 150. Contact: Loretta Giacoletto. Phone: 314-454-3873.

Internal Medicine

CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC & THROMBOTIC DISORDERS
For: Internists, Hematologists. Lecture, beginning Oct. 20, Chicago. Speaker: Hau C. Kwaan, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$150. Reg. limit: none. CME Credit: AMA Category 1, 16 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Medical Photography

FOURTH ANNUAL MEDICAL PHOTOGRAPHY WORKSHOP
For: M.D.'s, office staff. 1-day workshop, Oct. 28, Springfield, IL. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield, IL. Fee: \$55-pre. Reg. limit: none. CME Credit: AMA Category 1, 6 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine and Surgery

MEDICAL AND SURGICAL APPROACHES TO ACUTE COLON AND RECTAL DISEASES
For: Physicians. Symposium, October 26, Hillsboro, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. CME Credit: AAFP Elective, 4 hours; AMA Category 1, 4 hours. Reg. limit: none. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Neurology

NEUROLOGY UPDATE
For: Physicians. Symposium, October 7, Pittsfield, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. CME Credit: AAFP Elective, 4 hours; AMA Category 1, 4 hours. Reg. limit: none. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Neurotology

CLINICAL NEUROTOLOGY
For: Otolologists, Neurotologists. 4-day course, October 16-19, Chicago, IL. Speaker: Nicholas Torok, M.D. Sponsor: Dept. of Otolaryngology, A.L.S.M., Illinois Eye & Ear Infirmary, Neurotology Section, 1855 W. Taylor, Chicago, IL 60612. Cosponsor: American Neurotology Society. CME Credit: AMA Category 1, 28 hours. Fee: \$300. Contact: Nicholas Torok, M.D. Phone: 312-996-6517.

Obstetrics & Gynecology

RECERTIFICATION REVIEW IN OB-GYN
For: Obstetricians, Gynecologists. Lecture, beginning Oct. 30, Chicago. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$225. Reg. limit: none. CME Credit: AMA Category 1, 40 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Orthopaedics

MANAGEMENT OF COMMON FRACTURES
For: Family Practitioners. Lecture, beginning Oct. 23, Chicago. Speaker: Peter Altner, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$225. Reg. limit: 50. CME Credit: AAFP Prescribed, 35 hours; AMA Category 1, 35 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Psychiatry

DISTINGUISHED LECTURE SERIES
For: Psychiatrists, mental health professionals. Lecture, Oct. 18, 8:00 p.m., Offield Auditorium, Passavant Pavilion, 303 E. Superior, Chicago. Speaker: Daniel Offer, M.D., Professor of Psychiatry, U of C. Sponsor: Institute of Psychiatry, Northwestern Memorial Hospital and Dept. of Psychiatry and Behavioral Sciences, NUMS. Reg. limit: none. CME Credit: AMA Category 1, 1½ hours. Fee: none. Contact: Leon Diamond. Phone: 312-649-8058.

GENERAL PSYCHIATRY STUDY GROUP
For: Psychiatrists. Study group, 1st Sat. of mo., 9:00 a.m.-12:00 noon, Institute of Psychiatry, 320 E. Huron, Rm. 2011, Chicago. Sponsor: Institute of Psychiatry, Northwestern Memorial Hospital and Dept. of Psychiatry and Behavioral Sciences, NUMS. Reg. limit: 20. Fee: \$150. CME Credit: AMA Category 1, 24 hours. Reg. deadline: 9/30. Contact: Leon Diamond. Phone: 312-649-8058.

PSYCHOANALYTIC STUDY GROUP
For: Psychiatrists. Study group, 3rd Sat. of m., 9:00 a.m.-12:00 noon, Institute of Psychiatry, 320 E. Huron, Rm. 2011, Chicago. Sponsor: Institute of Psychiatry, Northwestern Memorial Hospital and Dept. of Psychiatry and Behavioral Sciences, NUMS. Reg. limit: 20. Fee: \$150. CME Credit: AMA Category 1, 24 hours. Reg. deadline: 9/30. Contact: Leon Diamond. Phone: 312-649-8058.

RECENT ADVANCES IN PSYCHIATRY

For: Psychiatrists. Lecture, beginning Oct. 23, Chicago. Speaker: Domeena Renshaw, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$225. Reg. limit: 125. CME Credit: AMA Category 1, 40 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Psychiatry

ILLINOIS PSYCHIATRIC SOCIETY 5th ANNUAL FALL WEEKEND MEETING

For: Psychiatrists, other physicians. 3-day lecture/workshop, October 6-8, Hyatt Regency O'Hare, Chicago, IL. Sponsor: Illinois Psychiatric Society, 55 E. Monroe, Suite 3510, Chicago, IL 60603. CME Credit: AMA Category 1, 13.5 hours. Fee: \$35. Reg. limit: none. Reg. deadline: 9/25. Contact: Wendy Smith. Phone: 312-782-1654.

Radiology

DIAGNOSTIC IMAGING OF THE GASTROINTESTINAL TRACT

For: Radiologists. 4-day course, Oct. 12-15, Lake of the Ozarks, MO. Sponsor: American College of Radiology. Fee: \$225. CME Credit: AMA Category 1, 13 hours. Contact: Walter Whitehouse, M.D., Dept. of Rad., U of Michigan Hospital, Ann Arbor, Michigan 48109.

Surgery

SPECIALTY REVIEW IN GENERAL SURGERY, PART I
For: Surgeons. Lecture, beginning Oct. 23, Chicago. Speaker: Robert Baker, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$425. Reg. limit: 400. CME Credit: AMA Category 1, 94 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Surgery

CLINICAL CONGRESS
For: Physicians. 5-day lecture, October 16-20, San Francisco, CA. Sponsor: American College of Surgeons, 55 E. Erie, Chicago, IL 60611. CME Credit: AMA Category 1. Contact: Ginny Clark. Phone: 312-664-4050.

NOVEMBER

REGIONAL ANESTHESIA

For: Anesthesiologists. Lecture, beginning Nov. 13, Chicago. Speakers: Vincent Collins, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$325. Reg. limit: 10. CME Credit: AMA Category 1, 40 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Anesthesia

Family Medicine

MANAGEMENT OF THE ACUTE CARDIAC PATIENT
For: Family Practitioners. Lecture, beginning Nov. 29, Chicago. Speaker: Kenneth Rosen, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$175. Reg. limit: 75. CME Credit: AMA Category 1, 21 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Internal Medicine

RESPIRATORY DISEASE
For: M.D.'s. Symposium, Nov. 30, Jacksonville, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AAFP Elective, 4 hours; AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE
For: M.D.'s. Symposium, Nov. 8, Harrisburg, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

BLOOD GASES-ELECTROLYTE IMBALANCE-HYPERALIMENTATION
For: M.D.'s. Symposium, Nov. 4, Highland, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

6TH ANNUAL WEBER MEDICAL CLINIC
For: M.D.'s. Clinic, Nov. 4, Olney, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

DIAGNOSIS AND TREATMENT OF ANAEROBIC INFECTIONS OF THE LUNG
For: M.D.'s, residents. Lecture, Nov. 15, 11:00 a.m., Auditorium, Martha Washington Hospital, 4055 North Western Ave., Chicago 60618. Speaker: Haragopal Thadepalli, M.D., Martin Luther King, Jr. General Hospital, Los Angeles, CA. Reg. deadline: 11/14. Fee: none. CME Credit: AMA Category 1, 1 hour; AAFP Elective, 1 hour. Contact: Fernando Villa, M.D. Phone: 312-583-9000 ext. 331.

Internal Medicine, Family Medicine

EMERGENCY CARDIOLOGY—DIAGNOSIS AND THERAPY

For: M.D.'s. Symposium, Nov. 30-Dec. 1, St. Louis, MO. Sponsor: Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Fee: \$120. Reg. limit: 150. CME Credit: AMA Category 1, 12 hours; AAFP Elective, 12 hours. Contact: Loretta Giacoletto. Phone: 314-454-3873.

Medicine

ADVANCES IN MEDICINE

For: Internists. Lecture, beginning Nov. 13, Chicago. Speaker: Sheldon Waldstein, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$225. Reg. limit: 100. CME Credit: AMA Category 1, 35 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Neurology

RECENT ADVANCES IN NEUROLOGY

For: Neurologists. Lecture, beginning Nov. 13, Chicago. Speaker: Neil Allen, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$225. Reg. limit: 75. CME Credit: AMA Category 1, 40 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Obstetrics & Gynecology

ADVANCES IN OBSTETRICS & GYNECOLOGY

For: Obstetricians, Gynecologists. Lecture, beginning Nov. 30, Chicago. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$175. Reg. limit: 100. CME Credit: AMA Category 1, 24 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

OB/GYN IN GENERAL PRACTICE

For: M.D.'s. Symposium, Nov. 16, Mt. Vernon, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

MANAGEMENT OF HIGH RISK OBSTETRICAL & NEWBORN PROBLEMS

For: Obstetricians, Pediatricians. Lecture, beginning Nov. 13, Chicago. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$250. Reg. limit: 100. CME Credit: AMA Category 1, 50 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Ophthalmology

CLINICAL UPDATE IN GLAUCOMA AND CORNEAL AND EXTERNAL DISEASE

For: Ophthalmologists. Lecture, Nov. 9-10, Chicago. Sponsor: Dept. of Ophthalmology, U of I, 1855 W. Taylor, Chicago 60612. Fee: \$150. Reg. limit: 60. CME Credit: AMA Category 1. Contact: Carmen Carasco. Phone: 312-996-8023.

Orthopedics

RHEUMATOLOGY AND JOINT RECONSTRUCTION

For: M.D.'s. Symposium, Nov. 9, Quincy, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

SPINAL PROBLEMS

For: M.D.'s. Symposium, Nov. 15, Belleville, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Psychiatry

DIAGNOSIS & MANAGEMENT OF EMOTIONAL PROBLEMS IN CHILDREN & ADULTS

For: Family Practitioners. Lecture, beginning Nov. 20, Chicago. Speaker: Domeena Renshaw, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$150. Reg. limit: 100. CME Credit: AAFP Prescribed, 17 hours; AMA Category 1, 17 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Surgery

SPECIALTY REVIEW IN SURGERY, PART II

For: Surgeons. Lecture, beginning Nov. 27, Chicago. Speaker: Robert Baker, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: \$425. Reg. limit: 300. CME Credit: AMA Category 1, 99 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

Urology

104TH ANNUAL MEETING OF SOUTHERN ILLINOIS MEDICAL ASSOCIATION

For: M.D.'s. Lecture, Nov. 9, Village of Muddy, IL. Sponsor: Southern Illinois Medical Association. Cosponsor: Illinois Academy of Family Physicians. Reg. deadline: none. Fee: none. Reg. limit: none. CME Credit: AMA Category 1, 4 hours. Contact: Dale Rosenberg, M.D., Suite 3-E, 6401 W. Main St., Belleville, IL. Phone: 618-398-5600.

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Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ARCOLA: Wanted-American trained F.P. to join established F.P. in active practice. Must do some O.B. Guaranteed salary and benefits. Eventual partnership. Robert N. Arrol, M.D., 126 S. Locust, Arcola, 61910. (217) 268-4444, or 268-4404. (12)

ATKINSON: Due to recent death of town's physician, a modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles from Peoria. All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235. (309) 936-7566. (12)

CHICAGO: Opportunities Available for Family Practitioners in a single specialty clinic setting. Association as a satellite facility with a 265 bed community hospital. Opportunity to build own practice with financial assistance available. Contact: Teryl R. Filebark, 1044 N. Francisco Ave., Chicago 60622. (312) 278-8800. (9)

CHICAGO (desirable suburb): Older general practitioner has excellent office facilities to share with younger G.P. Objective: need help with practice. Younger man may have guarantee to take over practice in near future. Hospital staff appointment available. All replies confidential. Box MK, Physician Recruitment Program, ISMS. (9)

ELGIN: Psychiatrist, $\frac{3}{4}$ time position with CMHC. Provide leadership and direction of medical and psychiatric aspects of clinical program, consult with staff, provide direct service to a wide variety of patients. Experience: past residency, preferably Board certified. Resume and salary requirements would be helpful to: Jack Crook, Director of Programs, Fox Valley Mental Health Center, 384 Division, Elgin, 60120, (312) 695-1115. (10)

FAIRBURY: Population 3,500. Rural area serving a population of more than 16,000. Excellent practice opportunity for family practitioner or internist interested in family practice. Enjoy life and your practice in an area which offers excellent facilities and a per-

sonal, friendly atmosphere; join the staff of 112-bed JCAH accredited community hospital. Write: Frank Brady, Administrator, Fairbury Hospital, Fairbury, 61739, or call collect (815) 692-2346. (10)

LISLE: Physician needed to assist me in handling my very extensive private family practice. Salary open, good opportunity for this relationship to merge into a partnership association. CONTACT: M. Sinkovits, 4513 Lincoln Ave., Lisle 60532. (312) 968-2735. (12)

MINIER: General or family practitioner for rich agricultural area near Bloomington. Large practice waiting due to death of doctor. Office with X-ray and other equipment, very reasonable. Unusual opportunity. Contact: Harvey Graff, Minier 61759. (309) 392-2345 or 392-2120. (10)

OSWEGO: Family physician or internist to join group of four in a small town primary care clinic. Two full-service hospitals nearby. One hour west of Chicago. Dr. A. Haan, Oswego, 60543. (312) 554-8431. (11)

OTTAWA: Opening in fields of Internal Medicine and Family Practice with multi-specialty group of nine physicians. Community, 20,000 plus. 154 bed hospital under five years old. Latest equipment One and one-half hours from Chicago and Peoria. Near State Parks. Excellent school system. Close to Jr. College and State Universities. Salary negotiable. CONTACT: Mrs. Van Buren, Ottawa Medical Center, 313 W. Madison, Ottawa 61350. (815) 433-1010. (10)

PEORIA: Emergency physician—Unique opportunity to start on the ground floor with fee-for-service group in 550-bed medical center seeing 27,000 ER visits. Need career-minded physician for three 16-hour shifts per week with four weeks paid vacation. Compensation 57K with excellent corporate benefits plus incentive compensation. Flexible scheduling to allow individual pursuits in university town of 250,000 in Central Illinois. Contact: Hospital Emergency Physicians S.C., 221 Northeast Glen Oak, Peoria, 61636; phone 309-672-4974. (8)

WAUKEGAN: Population 67,000, northern Chicago Suburb. Newly remodeled medical center near hospital. Looking for Internist, Family Physician. Contact Washington Center, 1515 Washington St., Waukegan 60085, Y. Lee, M.D. 312-336-2221 or 729-5407. (9)



Illinois Medical Journal

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and

acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium[®] (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose[®] packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs[®] (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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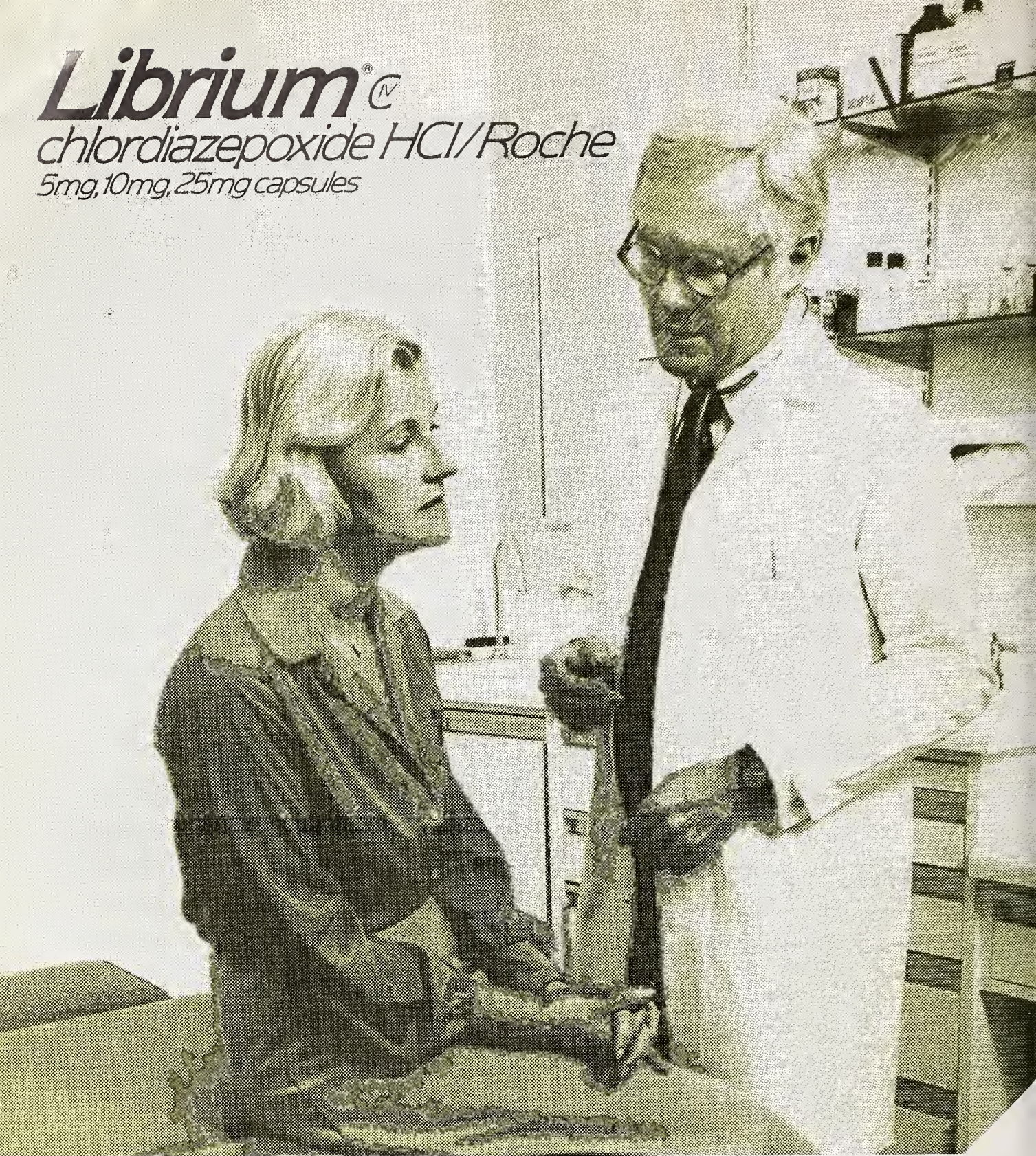
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Please see preceding page for a summary of product information.

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Illinois Medical Journal

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Volume 154, Number 4 - October 1978

UNIV OF CALIF-SAN FRANCISCO
ACQUISITIONS DIVISION
SAN FRANCISCO

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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REPORT

FOR *Illinois Physicians*

Utilization of Cost-Effective Programs

Illinois Blue Cross and Blue Shield is urging physicians, hospital administrators and all providers of patient care to utilize as extensively as possible the Plan's cost effective programs to conserve hospital and medical care expenses.

In the August issue of the "Blue Cross and Blue Shield Report for Illinois Physicians," the Pre-Admission Testing program for surgical patients (PAT) and the Ambulatory Surgery program were described and their cost-saving advantages emphasized.

Two additional cost-effective programs of the Plan—Coordinated Home Care and the Extended Care Facility program—are summarized below:

Further information on these programs is available from the Public Relations Department of Blue Cross and Blue Shield, 233 North Michigan Ave., Chicago, Illinois 60601.

Coordinated Home Care: Many hospital patients are going home earlier, because of Blue Cross and Blue Shield's Coordinated Home Care benefit program. With the doctor's permission, patients who are Blue Cross-Blue Shield members may be released directly into a program of recuperation and treatment at home where further medical and nursing care is provided.

The program is coordinated through the participating hospital in which the patient is receiving care and a participating Home Health Agency. It serves a two-fold purpose: The patient recuperates in the comfortable surroundings of his home, and the costs of care are reduced substantially in eliminating the expenses of a prolonged hospital stay.

A total of 58 hospitals and 32 home nursing agencies participate in this program. Many Blue Cross and Blue Shield subscribers are automatically covered for Coordinated Home Care.

To be eligible for the program, a patient must be directed into the program by his or her physician; require nursing service with continued hospital services or supplies; have inpatient hospital benefit days available under Blue Cross and doctor visits available under Blue Shield; be discharged from the hospital directly into the program; want to be cared for at home, have an adequate home situation; and require care directly related to the

condition that required hospitalization.

Blue Cross will pay for the services of a visiting nurse and physical therapy from the participating agency and for such services as medication, dressings, medical supplies, lab tests and x-rays from a participating hospital.

Blue Shield will pay the Usual and Customary fee of the attending physician for visits to the patient's home and for one office visit while the patient is under the Coordinated Home Care program.

The maximum number of Coordinated Home Care visits allowed are three for each unused hospital benefit day in a subscriber's Blue Cross certificate. For example, if a certificate provides for 120 days of hospital benefits and only 60 days are spent in the hospital, the patient has 180 eligible days for Coordinated Home Care, provided the need is acute and verified by the attending physician. Each visit by the attending physician counts as one benefit day. In all cases, verification of need is required every 30 days.

Extended Care Facility Program: Blue Cross and Blue Shield's Extended Care Facility program is designed to maintain quality care while holding down costs. An Extended Care Facility is a specially qualified facility staffed and equipped to provide comprehensive post-acute hospital and rehabilitative inpatient care after an early transfer from a hospital. It must have a contract with the Plan at the time the Blue Cross member is admitted.

An Extended Care Facility may be recommended for a patient after surgery or a serious illness when the extensive services of a general hospital are not required for a successful recovery. A supportive or maintenance level of care, residential care and custodial care are not covered.

The Extended Care Facility program increases the amount of benefit days for Blue Cross and Blue Shield subscribers. Benefits entitle the patient-subscriber to two days of care for each unused hospital benefit day under Blue Cross. Blue Shield pays for physician visits on the same basis as inpatient visits—with each visit counting as one daily visit.

A total of 57 facilities now qualify as Blue Cross-approved Extended Care Facilities. The names and locations of the facilities are available from Blue Cross and Blue Shield.

Daily Visit Charges for Inpatient Hospital Visits

Physicians frequently submit Medicare claims, or bill their patients, for hospital visits charging a single, inclusive daily visit rate for each day the patient is hospitalized. If a patient is hospitalized for 30 days, for instance, the charge would be for 30 visits.

It is the responsibility of the physician to provide adequate documentation of these visits; an entry should be made in the hospital record that indicates the date of each visit. Physicians may feel that, since they are responsible for the total care of a patient, this entitles them to reimbursement for every day that the patient is hospitalized, even though on certain days no identifiable service was rendered. Payment for medical care or medical management on this basis would be in conflict with Medicare coverage rules which state that "the physician must examine the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment."

A rule of the hospital that the physician is required to visit patients daily is not considered a sufficient basis for the carrier to pay each daily visit. Acceptable documentation would be a physician's progress notes indicating the dates he visited the patient, or an entry in the physician's orders. In a teaching hospital setting, the medical record must contain signed or countersigned notes by the supervisory physician who is billing for the visits.

The Medicare carrier does not always check routinely for hospital record documentation. However, in cases where a complaint of nonrendition of services is received, the records of that physician will be reviewed. Payment may be denied if the review fails to show the necessary documentation, or, if the review is on a postpayment basis, a physician could be asked to refund a payment. *Proper documentation always provides proof of visits made in case a patient raises a question with the Medicare carriers or his Social Security office regarding charges billed for visits.*

Changes in Participation and Certification of Laboratory Procedures

Notices were received from the Medicare Bureau of the following changes in participation and certification of tests and procedures of laboratories in the Medicare program:

Approved for Participation:

Cos Building Laboratory, 2500 Ridge Road,

Evanston, Ill. 60201 (Provider Number 14-8355) has been approved for participation in the Medicare program, effective April 13, 1978. The laboratory is approved to perform the following tests and procedures: 130-Parasitology; 200-Serology; 310-Routine Chemistry; 320-Clinical Microscopy; 630-Diagnostic Cytology; 710-EKG Services.

Changes in Approved Tests and Procedures:

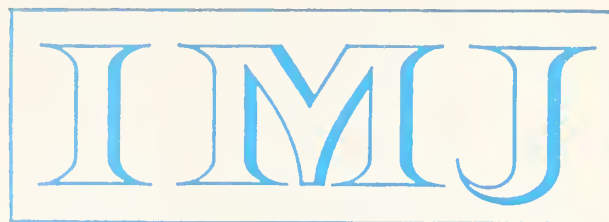
Island Medical Laboratory, Inc., 8452 Stony Island Ave., Chicago, Ill. 60617 (Provider Number 14-5247) has been approved to perform Procedure 630-Diagnostic Cytology, effective January 15, 1978. The laboratory is also approved to perform Procedure 110-Bacteriology; Procedure 200-Serology; Procedure 310-Chemistry Routine; Procedure 320 Clinical Microscopy; Procedure 400-Hematology; Procedure 510-Blood Group and Rh Typing.

Greenview Clinical Laboratories, Inc., 2752 West Fullerton Ave., Chicago, Ill. 60647 (Provider Number 14-8239) is no longer approved to perform Procedures 330-Chemistry-Other and 510-Blood Group and Rh Typing. The laboratory is approved to perform Procedures 110-Bacteriology; 310-Chemistry Routine; 320-Clinical Microscopy; 200-Serology; 130-Parasitology; 510-Blood Group and Rh Typing; 710-EKG Services; 630-Diagnostic Cytology.

Ace Diagnostic Limited, 1411 West Irving Park Road, Chicago, Ill. 60613 (Provider Number 14-8293) is longer approved to perform Procedures 130-Parasitology and 330-Chemistry-Other. The laboratory is approved to perform Procedures 110-Bacteriology; 200-Serology; 310-Chemistry Routine; 320-Clinical Microscopy; 510-Blood Group and Rh Typing; 630-Diagnostic Cytology; 710-EKG Services; 400-Serology.

Lius Medical Laboratory, Inc., 1429 West Irving Park Road, Chicago, Ill. 60613 (Provider Number 14-8320) is no longer approved to perform Procedures 130-Parasitology; 330-Chemistry-Other and 510-Blood Group and Rh Typing. The laboratory is approved to perform Procedures 110-Bacteriology; 200-Serology; 310-Routine Chemistry; 320-Clinical Microscopy and 630-Diagnostic Cytology.

St. Luke Family Health Center, Inc., 1414 South Indiana Ave., Chicago, Ill. 60605 (Provider Number 14-8343) is no longer approved to perform Procedures 330-Chemistry-Other; 510-Blood Group and Rh Typing; 630-Diagnostic Cytology; and 710-EKG Services. The laboratory is approved to perform Procedures 110-Bacteriology; 130-Parasitology; 200-Serology; 310-Routine Chemistry; 320-Clinical Microscopy; and 400-Hematology.



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Clinics for Crippled Children Listed for November

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-four general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be nine special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- November 1 Hinsdale—Hinsdale Sanitarium
- November 1 Mt. Vernon—Good Samaritan Hospital
- November 2 Effingham—St. Anthony Memorial Hospital
- November 2 Pittsfield—Illini Community Hospital
- November 2 Sterling—Community General Hospital
- November 2 Lake County Cardiac—Victory Memorial Hospital
- November 3 Division Cardiac—U. of I. at the Medical Center
- November 7 Park Ridge Cardiac—Lutheran General Hospital
- November 8 Champaign—McKinley Hospital
- November 8 Joliet—St. Joseph's Hospital
- November 8 Chicago Heights Gen.—St. James Hospital
- November 9 DuQuoin—Marshall Browning Hospital
- November 9 Springfield—St. John's Hospital
- November 9 Macomb—McDonough District Hospital
- November 10 Chicago Heights Cardiac—St. James Hospital
- November 13 Peoria Cardiac—St. Francis Hospital
- November 14 Peoria—St. Francis Hospital
- November 14 East St. Louis—Christian Welfare Hospital
- November 15 Centralia—St. Mary's Hospital
- November 15 Rockford—St. Anthony's Hospital
- November 15 Springfield Ped-Neuro—St. John's Hospital
- November 15 Elgin—Sherman Hospital
- November 15 Evergreen Park—Little Company of Mary Hospital
- November 15 Chicago Heights Gen.—St. James Hospital
- November 16 Elmhurst Cardiac—Memorial Hospital of DuPage County
- November 17 Chicago Heights Cardiac—St. James Hospital
- November 17 Kankakee Cardiac—St. Mary's Hospital
- November 20 Maywood—Loyola Medical Center
- November 21 Rock Island—Moline Public Hospital
- November 21 Decatur—Decatur Memorial Hospital
- November 21 Belleville—St. Elizabeth's Hospital
- November 27 Peoria Cardiac—St. Francis Hospital
- November 28 Peoria—St. Francis Hospital
- November 28 Alton—Alton Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.





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Please see brief summary of prescribing information on preceding page.



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*By repeated determinations of the basal blood pressure,** and once the medical history, physical examination, including fundoscopic and routine laboratory tests,† have been completed, one is usually able to exclude secondary causes and to be reasonably comfortable with a diagnosis of primary or essential hypertension.

**The National Hypertension Program Study Committee, in September, 1972, recommended blood pressures exceeding 140/90 mm Hg be regarded as excessive for adult Americans under age 50. The World Health Committee ceiling has been 160/95 mm Hg.

†Hematocrit, urinalysis, creatinine (or urea nitrogen), triglycerides, cholesterol, uric acid, plasma glucose, serum potassium, electrocardiogram, and chest x-ray.

Please see brief summary of prescribing information on last page of advertisement for warnings, precautions, and adverse reactions.





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**Most common side effects are dry mouth, drowsiness, and sedation,
which generally tend to diminish with time.**

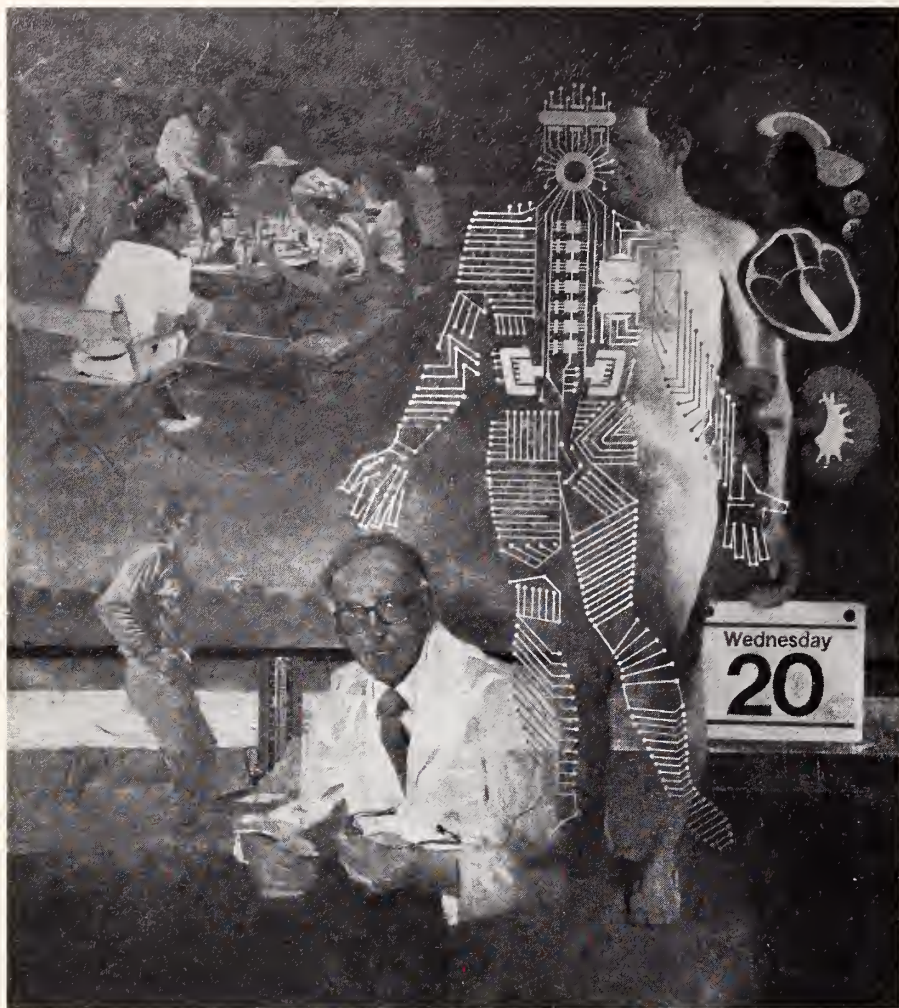
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Tablets of 0.1 and 0.2 mg

Catapres[®]

(clonidine HCl)

It gives you more than you expect of Catapres



Tablets of 0.1 and 0.2 mg

Catapres® (clonidine HCl) can help you shape his world

Counsel...and Catapres. They can help change the odds against your patient's future. And to change them even more, ask us for these from your Boehringer representative:

- A major new film on Methods of Compliance
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References:

1. Wilber JA, Barrow JS: Am J Med, 52 653-663, 1972.
2. Data on file at Boehringer Ingelheim Ltd.



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**Catapres® brand of
clonidine hydrochloride**
Tablets of 0.1 mg and 0.2 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon, vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

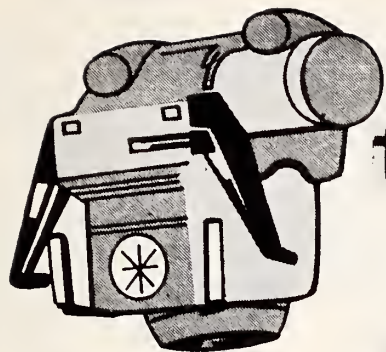
Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000.

For complete details, please see full prescribing information.

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the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STITCH SCHOOL OF MEDICINE

This month's case report was contributed by Michael Fine, M.D., an assistant professor of radiology and Enrique Palacios, M.D., a professor of radiology, affiliated with the Loyola University Medical Center.

This 8-year-old male presented to the Emergency Room with a history of head trauma following a seizure. A frontal and lateral skull x-ray were obtained.

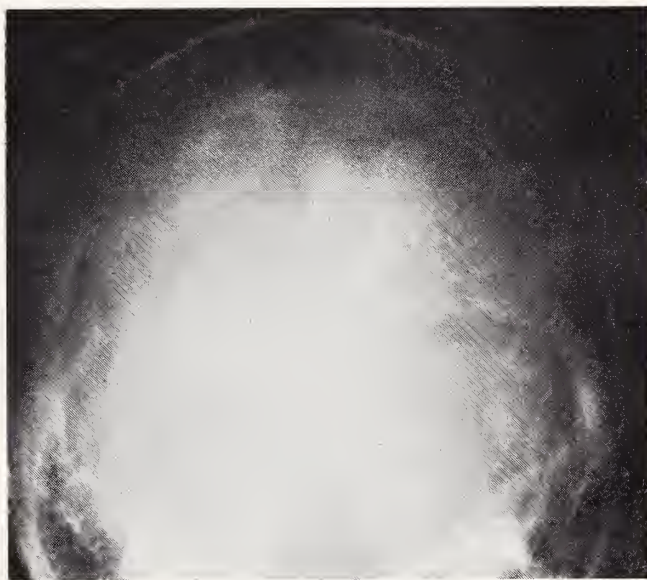
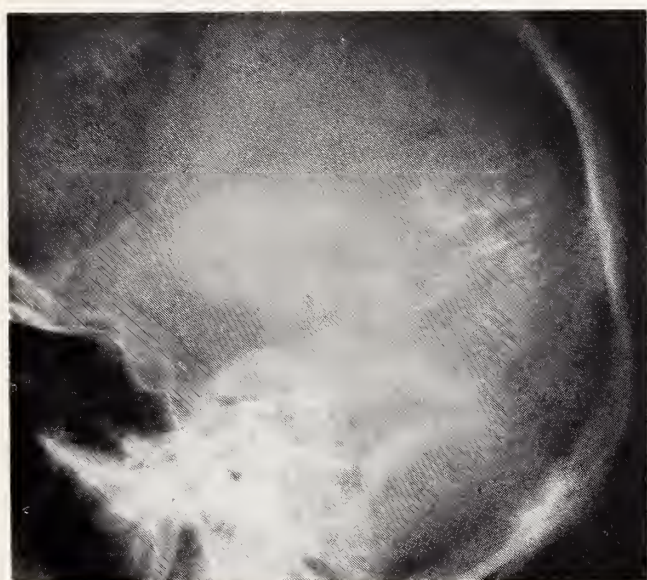


Figure 1

What's Your Diagnosis?

The findings are consistent with:

- (A) Calcified tumor
- (B) Post-inflammatory calcifications
- (C) Sturge-Weber syndrome
- (D) Radio-opaque material in the hair

(Continued on page 323)

A close-up photograph of a monarch caterpillar with its characteristic black, white, and orange stripes, crawling on a green milkweed stem. The plant has several clusters of small, white, star-shaped flowers. The background is a soft-focus green.

Wild beauty...or offending allergen?

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from Schering allergy research

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Prolonged duration of antihistamine action is inherent in the molecular structure...not due to tablet coatings or other slow release processes

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Patients can fit OPTIMINE into morning and evening routines...no need to carry medication. The easy-to-titrate, scored 1 mg. tablet permits dosage flexibility to meet individual patient requirements

No dyes

Contains no sensitizing dyes with their potential for causing allergic reactions

Optimine A practical antihistamine
to help allergy patients stay on therapy

CONTRAINDICATIONS Use in Newborn or Premature infants: This drug should not be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma; stenosing peptic ulcer, pyloroduodenal obstruction; symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma; increased intraocular pressure; hyperthyroidism; cardiovascular disease; hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined.

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils; flushing; and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977

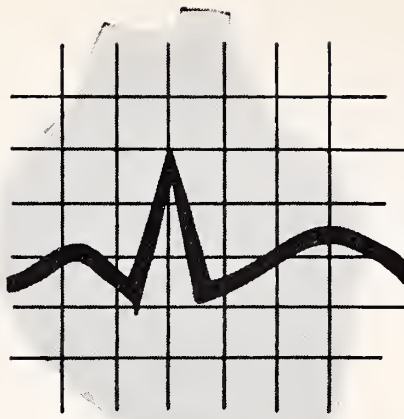
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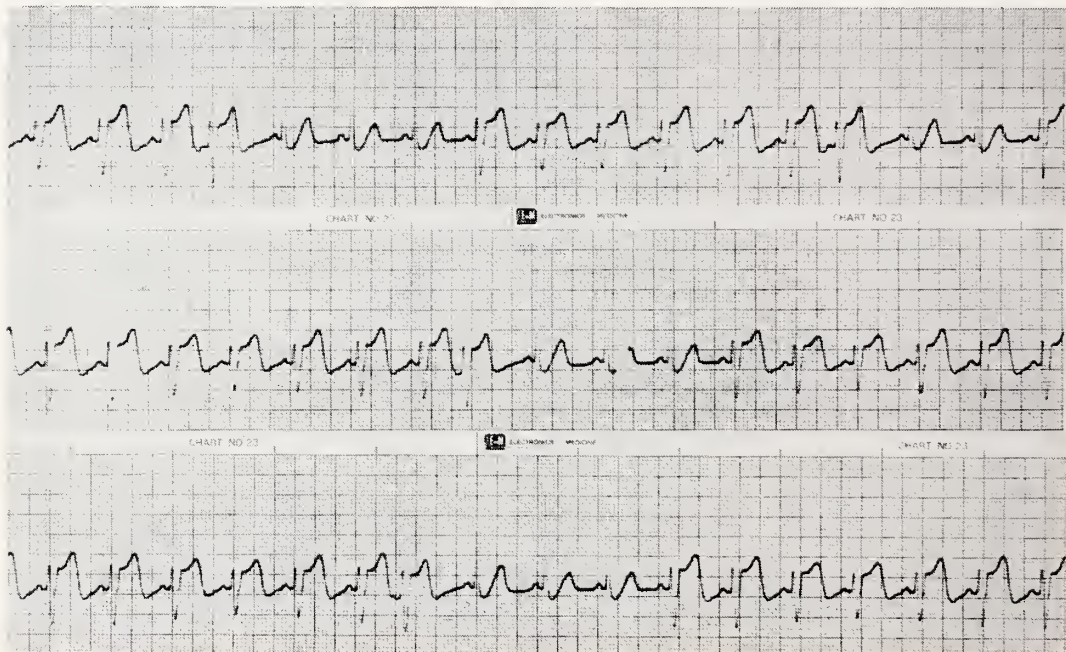
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ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D.,
PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine.

This is a 60-year-old man who came to the office complaining of worsening shortness of breath over the past six months. This progressed and was followed by paroxysmal nocturnal dyspnea and orthopnea. Past medical history was significant for inferior wall myocardial infarction eight years earlier. Physical examination demonstrated a grade 4/6 holosystolic murmur at the apex followed by a loud ventricular gallop (S_3). Cardiac catheterization demonstrated moderate pulmonary hypertension 50/20 with an elevated pulmonary capillary wedge pressure. The left ventricular angiogram showed severe mitral valvular regurgitation with an enlarged left atrium. The pulmonary veins were also visualized. Rupture of the papillary muscles of the mitral valve was suspected. Coronary arteriogram showed a 100% right coronary artery obstruction with few plaques in the left system. Open heart surgery with mitral valve replacement was performed. This long lead II rhythm strip was obtained on the first day following the surgery.



Questions:

1. The ECG shows:

- A. Premature atrial beats.
- B. Paroxysmal junctional tachycardia.
- C. Intermittent atypical complete left bundle branch block.
- D. Cycle dependent left anterior hemiblock.
- E. ST-T wave changes.

2. Treatment should include:

- A. An increase in digitalis medication.
- B. Quinidine 300 mg. every six hours orally.
- C. Atropine 0.4 mg. intravenously.
- D. Direct current cardioversion.
- E. Temporary demand pacemaker as prophylaxis for sudden asystole.

(Continued on page 328)



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Each capsule contains 50 mg. of Dyrenium[®] (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Makes Sense in Hypertension*

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

*** Warning**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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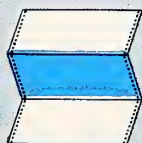
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Obituaries

***Berard, LeRoy, H.**, Oak Park, died September 6, 1978, at the age of 80. He was a 1929 graduate of the Rush Medical College. During his medical career, Dr. Berard served on the staff of Cook County Hospital and the Chicago Tuberculosis Sanitarium.

Brown, Cabot, San Francisco, died on September 17, 1978, at the age of 76. Dr. Brown was a former Chicagoan.

***Hardin, Parker C.**, Rockford, died August 25, 1978, at the age of 78. A 1927 graduate of Harvard, Dr. Hardin was a Diplomate with the American Board of Surgery and a Fellow of the American College of Surgeons.

Hollander, Fredrick G., California, died at the age of 67. Dr. Hollander was a former Chicago resident.

***Janda, Rudolph W.**, La Grange Park, died September 5, 1978, at the age of 58. Dr. Janda was a 1944 graduate of the University of Chicago.

***Kochenski, Richard V.**, Chicago, died on September 10, 1978. He was a 1935 graduate of the Chicago Medical School.

***Lewis, Calvin I.**, Glencoe, died September 20, 1978 at the age of 63. Dr. Lewis graduated from the University of Illinois in 1941. He was affiliated with St. Therese Hospital in Waukegan.

Lloyd, Donald, Elgin, died August 23, 1978, at the age of 61. He was a graduate of Northwestern Medical School. Dr. Lloyd was a past president of the Sherman Hospital Medical Staff.

***Mizock, Albert**, Chicago, died August 31, 1978, at the age of 72. Dr. Mizock was a 1934 graduate of the Chicago Medical School. During his years of practice, Dr. Mizock was on the staff of Walther Memorial and Central Community Hospitals.

Oberschneider, Paul, Elgin, died August 9, 1978, at the age of 58.

***Richter, Oscar**, Chicago, died September 6, 1978, at the age of 77. He was a 1927 graduate of the University of Chicago. Dr. Richter held staff positions on Belmont and St. Anne's Hospitals.

***Schmidt, Richard H.**, Chicago, died September 10, 1978, at the age of 58. Prior to his death, Dr. Schmidt was a radiologist on the staff of Illinois Masonic Medical Center. Formerly a resident of Valparaiso, Indiana, he was director of radiology at Porter Memorial Hospital.


Simunich, William A., Phoenix, Arizona, died August 10, 1978, at the age of 83. A former Chicagoan, Dr. Simunich served on the Staff of Mercy Hospital and the Lewis Memorial Maternity Center.

Ziegler, Rudolph, Oregon, died in an accident on August 10, 1978 at the age of 61. A former Chicagoan, Dr. Ziegler was an official of the Fellows of International College of Physicians. He was a graduate of the Chicago Medical College.

*Indicates ISMS member.

**Indicates member of the ISMS Fifty Year Club.

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Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

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Guest Editorial

Marketplace Choice as Deterrent To Government Price Controls

Editor's Note: The guest editorial below was submitted by the American Medical Association for your consideration with the following comment:

Alain G. Enthoven, the noted Stanford University economist, recently told the AMA Board of Trustees, "We're on the track to an increasingly regulated system (of health-care delivery)."

He added, "The alternative to increasing government regulation is a system of incentives for economy and fair-market competition as recommended by your National Commission on the Cost of Medical Care."

The AMA-created National Commission on the Cost of Medical Care has opened up a new horizon by emphasizing the need to restore the concept of free-marketplace choice in health-care delivery.

What does that mean?

Well, picture the delivery system as a marketplace where producers and consumers handle their transactions through insurers, private and public. The Cost Commission report recommends that producers and consumers have direct impact on decisions made in their behalf.

Consumers want to buy services at a lower annual rate of cost growth than the 11% it has averaged since 1966.

However, the marketplace right now is not functioning well. It was flexible in the days when consumers paid the producer directly. But the patterns of coverage offered by today's middleman insurers are largely standardized in benefits and therefore in costs.

The Cost Commission report suggests ways in which those patterns can be stimulated to offer a latitude and freedom of choice.

For instance, employees could choose among health-care plans in terms of premium price, whereas employer contributions to premiums would be the same for any plan. The employee selecting a plan less expensive than the employer contribution would either be reimbursed for the difference or receive additional benefits.

The report makes this general observation:

"Reliance on market mechanisms can lead to cost-effective production of output, and permit consumer preferences to play a key role in de-

termining what goods and services are available."

Unfortunately, this leeway cannot control costs all by itself. Nor does the marketplace assure care to the poor and uninformed, and their health-care costs could continue to rise sharply.

Hence, there must be some reliance on provider self-regulation and on local regulation if the overall tab is to be kept in line. No federal controls are recommended by the report.

Self-regulation would include cost-containment initiatives in the private sector of care, among third-party payers, and in medical practice. Says the report:

"In the past, providers have considered primarily the medical needs of their patients. The Commission believes that providers must now take steps to make cost-effective utilization recommendations without sacrificing the quality of care. There are a number of programs that can be undertaken within the health-care system that are not dependent on major changes in the delivery system."

The chief value of the report is that it brings many ideas and groups together in a coordinated program for genuine action. Some of the ideas are old but have never been implemented. Group responsibilities include those placed on the consumer.

The upshot could be a momentum that would head off arbitrary, unwieldy federal formulas for cost containment. Developed after a year and a half of intensive study and effort, the Cost Commission report presents credible alternatives to those formulas.

◀
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Adverse Reactions: Theophylline may exert same stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 µg/ml.

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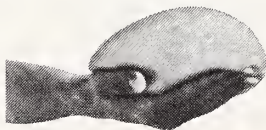
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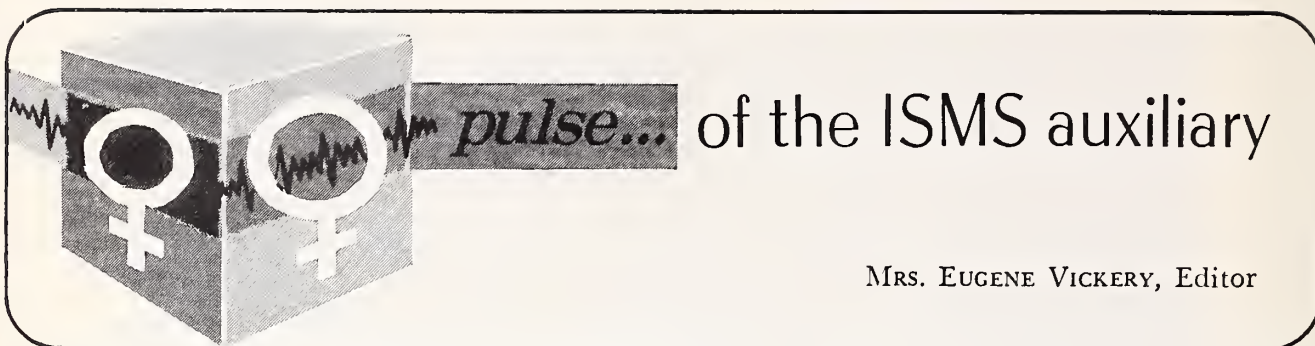
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Growth Patterns

Medical Marriage:

Joys and Sorrows

MRS. EARL V. KLAREN, PRESIDENT, ISMSA

The American Medical Association Auxiliary Convention was held June 18-21 in St. Louis, Missouri. Those who attended have reported a valuable educational experience. The following piece is excerpted from the AMAA publication, "Facets," detailing one presentation from that meeting. It reports several interesting comments on medical marriage.

A five-member panel, moderated by Peter A. Martin, M.D., clinical professor of psychiatry at Michigan and Wayne State University Medical Schools and member of the AMA Section Council on Psychiatry, examined the special stresses a medical career places on a marriage.

Mrs. Mary Glasgow, a physician's wife who is a poet and artist, presented a personal view of the medical marriage in a talk she humorously titled "On Being Married to God." "You can never escape his fan club," nor the "phonecalls at all hours," she said in noting the annoyances of the medical marriage. But, she said, these are balanced by special benefits. "There is a real pleasure in the role of 'Frau Doctor' or 'Frau Professor,'" she maintained. Because a medical career is so demanding of the physician's time and energy, the nonphysician member of a cou-

ple may feel cheated. But, said Mrs. Glasgow, if the spouse has a positive attitude, these problems can be overcome. "The woman who considers herself entitled to the good things in life" such as a fulfilling home life and a career, "seems to be the one who gets those things," she said.

Ellen M. Berman, M.D., Director, Division of Family Study, University of Pennsylvania, discussed the stages of adult development, explaining how these stages relate to the physician's time frame and how they can affect relationships. "Each decade asks us different things, and this affects our marriage greatly," she noted.

Stephanie Cavanaugh, M.D., assistant professor of psychiatry, Rush Medical School, Chicago, discussed the socialization process taking place in medical schools. Dr. Cavanaugh drew upon her professional experience as well as personal

experience with her physician-husband. "Medical school and residency training programs are still structured in such a way that time for a personal life is almost non-existent," she said.

That structure is slowly changing, she noted, adding that in the meantime, spouses should "build a solid support system of friends, family, neighbors, and household help." and have "gratifying activities and careers outside the home."

H. Waldo Bird, clinical professor of psychiatry at St. Louis University, provided an inside view of the marriage counseling therapy room. After detailing the warning signs of problems in a marriage, Dr. Bird offered an unbeatable view of a marriage relationship. "There really is no more optimal situation for two people to learn who they are than in the framework of marriage," he said.

Special Note

Fall Conference for the southern counties will be held Thursday, November 9, 1978, at the Belleville Ramada Inn. For further information about the exciting program, as well as reservations, please contact program co-chairmen Mrs. Thomas Meirink or Mrs. Andrew Gregowicz, both of Belleville.

ISMS Travel Programs

The following ISMS-sponsored travel programs have been scheduled for 1979:

Feb. 27-Mar. 13—Africa (Morocco/Kenya)

June 24-July 5—Rhine Cruise (Munich, Rhine River, Brussels)

July 30-Aug. 12—European Adventure (Paris, Interlaken, Florence)

Sept. 2-15—Danube Cruise (Vienna to Istanbul)

Reservations cannot be accepted without the official form printed in promotional brochures, which will be mailed to all ISMS members and auxiliary at least five months in advance. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by tour operators. For further information, please contact ISMS headquarters.

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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

NOVEMBER

Family Medicine

UPDATE—PRIMARY CARE MEDICINE

For: GP's, FP's, Internists. Lectures, Nov. 3 & 17, Chicago. Sponsor: Grant Hospital, 550 W. Webster, Chicago 60614. Fee: none. Reg. limit: 200. CME Credit: AMA Category 1, 2 hours. Contact: P. Colon. Phone: 312-883-2112.

Family Therapy

WORKING WITH FAMILIES IN A GENERAL MEDICAL PRACTICE

For: MD's, medical health practitioners. Seminar series, Nov. '78-June '79, Oak Park. Speakers: James McCoy, MD, Charles Kramer, MD. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Contact: Jeanne Robinson. Phone: 312-649-7285.

Family Therapy

SEVENTH ANNUAL FALL CONFERENCE: CHANGING THE FAMILY BELIEF SYSTEM

For: MD's. 2-day conference, Nov. 3-4, 9:30 a.m.-4:30 p.m., Chicago. Speaker Peggy Papp, ACSW. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. CME Credit: AMA Category 1, 12 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

Family Therapy

PARADOXICAL TECHNIQUES IN FAMILY THERAPY

For: MD's. 1-day workshop, Nov. 16, Chicago. Speaker: Robert Mark, Ph.D. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. CME Credit: AMA Category 1, 6 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

Forensic Medicine

REVIEW OF CURRENT FORENSIC PATHOLOGY CASES
For: MD's, DDS's, LIB's. Workshop/lecture, Thursdays, 2:00 p.m., Chicago. Sponsor: Office of the Medical Examiner, Cook County, Illinois, 1828 W. Polk St., Chicago 60612. Fee: none. Reg. limit: 50. Contact: Robert Stein, MD. Phone: 312-443-5017.

Infections and Antibiotics

UPDATE ON COMMON INFECTIONS AND ANTIBIOTICS
For: Primary care physicians. Lecture, Nov. 29, Rockford. Sponsor: Dept. of Family Practice, Rockford School of Medicine, Office for Continuing Education, 1601 Parkview Ave., Rockford, IL 61101. Fee: \$10. Reg. limit: none. CME Credit: AMA Category 1. Contact: Jacqueline Parochka. Phone: 815-987-7140.

Infectious Diseases

RECENT ADVANCES IN INFECTIOUS DISEASES

For: MD's, residents, students. Lecture series, Nov. '78-May '79, Rockford. Sponsors: Division of Infectious Diseases, Rockford School of Medicine, Office for Continuing Education, 1601 Parkview Ave., Rockford, IL 61101. Fee: \$25. Reg. limit: none. CME Credit: AMA Category 1, 18 hours. Contact: Jacqueline Parochka. Phone: 815-987-7140.

Internal Medicine

BLOOD GASES—ELECTROLYTE IMBALANCE—HYPERALIMENTATION

For: MD's, office staff. Symposium, Nov. 14, 6:00-10:00 p.m., Highland. Sponsor: SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. Fee: \$25 pre. Reg. limit: none. CME Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medical/Legal

23rd MEDICAL/LEGAL SEMINAR FOR LAKE COUNTY
For: MD's, DDS's, nurses, pharmacists, pharmaceutical representatives, ancillary medical personnel. 1-day seminar, Nov. 15, Waukegan. Sponsor: St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. Reg. deadline: 11/13. Fee: \$2.50. Reg. limit: none. CME Credit: AMA Category 1, 5 hours; AAFP Elective, 5 hours; AOA, 5 hours. Contact: R. M. Adelman, DDS, MD, JD. Phone: 312-688-5800.

Medicine

CARDIOLOGY CONFERENCE

For: open. Case presentations, Saturdays, 8:00 a.m., Nov. '78-June '79, Evanston. Sponsor: St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. Fee: none. Reg. limit: none. Contact: Mitchel Byrne, MD. Phone: 312-492-6227.

Medicine

NEWER ANTIBIOTICS FOR GRAM-NEGATIVE INFECTIONS

For: MD's, interns. Lecture, Nov. 22, 11:00 a.m., Chicago. Speaker: Mary Carruthers, MD. Sponsor: Martha Washington Hospital, 4055 No. Western Ave., Chicago 60618. Fee: none. Reg. limit: none. CME Credit: AMA Category 1, 1 hour; AAFP Elective, 1 hour. Contact: Fernando Villa, MD. Phone: 312-583-9000 x 331.

Medicine

NEUROLOGY CONFERENCE

For: open. Lecture series, Nov. '78-June '79, 2nd/4th Tuesday, Evanston. Speaker: M. M. Ilahi, MD. Sponsor: St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. Reg. limit: none. Fee: none. Contact: Mitchel Byrne, MD. Phone: 312-492-6227.

Medicine

NEPHROLOGY

For: open. Lecture series, Nov. '78-June '79, 2nd/4th Wednesday, Evanston. Sponsor: St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. Fee: none. Reg. limit: none. Contact: Mitchel Byrne, MD. Phone: 312-492-6227.

Medicine

PULMONARY DISEASES CONFERENCE

For: open. Lecture series, Nov. '78-June '79, 1st/3rd Tuesdays, Evanston. Speaker: M. J. Kim, MD. Sponsor: St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. Reg. limit: none. Contact: Mitchel Byrne, MD. Phone: 312-492-6227.

Medicine

RESPIRATORY DISEASE

For: MD's, office staff. Symposium, Nov. 30, 1:00-5:00 p.m., Jacksonville. Sponsor: SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. Fee: \$25 pre. CME Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

For: MD's, office staff. Symposium, Nov. 8, 1:00-5:00 p.m., Herrin. Sponsor: SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. Fee: \$25 pre. Reg. limit: none. CME Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

GI CONFERENCE

For: open. Lecture series, Nov. '78-March '79, Saturdays, Evanston. Speaker: Fernando Villa, MD. Sponsor: St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. Fee: none. Reg. limit: none. Contact: Mitchel Byrne, MD. Phone: 312-492-6227.

Medicine

BI-WEEKLY CLINICAL CONFERENCE

For: MD's, DDS's. Seminar Series, Thursdays, 8:00 a.m., Nov. '78-May '79, Mattoon. Sponsor: Sarah Bush Lincoln Health Center, Route 16, Mattoon, IL 61938. Fee: none. CME Credit: AMA Category 1. Contact: Byron Ruskin, MD. Phone: 217-258-2514.

Medicine

GI CONFERENCE

For: open. Lecture series, Nov. '78-June '79, Thursdays, 3:00 p.m., Evanston. Speaker: David Johnson, MD. Sponsor: St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. Fee: none. Reg. limit: none. Contact: Mitchel Byrne, MD. Phone: 312-492-6227.

Antibiotic Therapy—Medicine

ANTIBIOTIC CHOICES AND HOW TO MAKE THEM
For: MD's, interns. Lecture, Nov. 15, 11:00 a.m.-12:00 noon, Chicago. Speaker: Mary Carruthers, MD. Fee: none. Reg. limit: none. CME Credit: AMA Category 1, 1 hour; AAFP Elective, 1 hour. Contact: Fernando Villa, MD. Phone: 312-583-9000 x 331.

Obstetrics/Gynecology

OBSTETRICS/GYNECOLOGY IN GENERAL PRACTICE

For: MD's, office staff. Symposium, Nov. 16, 7:00-10:00 p.m., Mt. Vernon. Sponsor: SIU School of Medicine, 801 No. Rutledge Ave., P.O. Box 3926, Springfield, IL 62708. Fee: \$25 pre. Reg. limit: none. CME Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Obstetrics/Gynecology

PERINATAL MEDICINE SYMPOSIUM

For: MD's, office staff. Symposium, Nov. 9, 8:00-4:30 p.m., Springfield. Sponsor: SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. Fee: \$55 pre. Reg. limit: none. CME Credit: AMA Category 1, 6 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Pediatric Allergy

ALFRED S. TRAISMAN MEMORIAL LECTURE

For: MD's. Lecture Nov. 8, 12:00 noon, Chicago. Speaker: Harvey Colten, MD. Sponsor: Children's Memorial Hospital, 707 W. Fullerton, Chicago 60614. Fee: none. Reg. limit: none. CME Credit: AMA Category 1, 1 hour; AAFP Elective, 1 hour. Contact: Howard Traisman, M.D. Phone: 312-869-4300.

Pediatrics

PRIMARY CARE PEDIATRICS—A GENERAL OVERVIEW

For: Pediatricians, GP's, FP's. Lecture, Nov.-Jan., 2nd/4th Wednesday, Chicago. Sponsor: Grant Hospital, 550 W. Webster, Chicago 60614. Fee: none. Reg. limit: none. CME Credit: AMA Category 1. Contact: P. Colon. Phone: 312-883-2112.

SETTING UP A SEX CLINIC

For: MD's, Psychiatrists. Lecture, Nov. 15, 1:00-4:00 p.m., Forest Park. **Speaker:** Domeena Renshaw, MD. **Sponsor:** Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. **Fee:** \$15. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312-771-7000.

*Surgery***ENTERAL & PARENTERAL HYPERALIMENTATION**

For: MD's, office staff. Symposium, Nov. 1, 8:00-5:00 p.m., Springfield. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** \$55 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 6 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Surgery***SPINAL PROBLEMS**

For: MD's, office staff. Symposium, Nov. 15, 8:00-12:00 noon, Belleville. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** \$25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Surgery***RHEUMATOLOGY & JOINT RECONSTRUCTION**

For: MD's, office staff. Symposium, Nov. 9, 3:00-8:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** \$28 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Surgery—Medicine***TUMOR CONFERENCE**

For: open. Weekly lecture, Thursdays, 12:00 noon, Evanston. **Sponsor:** St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Fee:** none. **Reg. limit:** none. **Contact:** Mitchel Byrne, MD. **Phone:** 312-492-6227.

*Parent-Infant Bonding and Child Abuse***PROMOTION OF PARENT-INFANT BONDING—AN EFFECTIVE STEP TOWARD PREVENTION OF CHILD ABUSE**

For: MD's, nurses, social workers. Symposium, Nov. 2, 8:00 a.m.-4:00 p.m., Champaign. **Sponsor:** Carle Clinic Association and Carle Foundation, Education Dept., 602 W. University, Urbana, IL 61801. **Cosponsor:** UI School of Clinical Medicine. **Fee:** \$25. **Reg. limit:** none. **CME Credit:** AMA Category 1, 6 hours; AAFP Elective, 6 hours. **Contact:** Annette Lansford, MD. **Phone:** 217-337-3100.

DECEMBER

*Colposcopy***COLPOSCOPY**

For: MD's. Conference, Dec. 8-9, Chicago. **Sponsor:** Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago 60611. **Fee:** \$150. **CME Credit:** AMA Category 1, 12 hours. **Contact:** James Dyson, Ph.D. **Phone:** 312-649-8533.

*Family Medicine***UPDATE—PRIMARY CARE MEDICINE**

For: GP's, FP's, Internists. Lectures, Dec. 12 & 15, 8:00 a.m., Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **CME Credit:** AMA Category 1, 2 hours. **Contact:** P. Colon. **Phone:** 312-883-2112.

*Family Therapy***TECHNIQUES FOR WORKING WITH SEVERELY DISTURBED FAMILIES**

For: MD's. Workshop, Dec. 1, 9:30-4:30 p.m., Chicago. **Speaker:** Froma Walsh, Ph.D. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron St., Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **CME Credit:** AMA Category 1, 6 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Forensic Medicine***REVIEW OF CURRENT FORENSIC PATHOLOGY CASES**

For: MD's, DDS's, LIB's. Workshop/lecture, Thursdays, 2:00 p.m., Chicago. **Sponsor:** Office of the Medical Examiner, Cook County, Illinois, Chicago. **Fee:** none. **Reg. limit:** 50. **Contact:** Robert Stein, MD. **Phone:** 312-443-5017.

JAUNDICE

For: MD's, office staff. Symposium, Dec. 7, 1:00-5:00 p.m., DuQuoin. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL. **Fee:** \$25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Obstetrics/Gynecology***OBSTETRICS & OFFICE GYNECOLOGY**

For: MD's, office staff. Symposium, Dec. 7, 5:00-9:00 p.m., Lawrenceville. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** \$25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Psychiatry***OFFICE PSYCHIATRY**

For: MD's, office staff. Symposium, Dec. 14, 7:00-10:00 p.m., Effingham. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** \$25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Psychiatry***INTRODUCTION TO THE ART OF SELF-CARE & CONFLICT MANAGEMENT**

For: Psychiatrists, MD's. Lecture, Dec. 20, 1:00-4:00 p.m., Forest Park. **Speaker:** Yetta Bernhard, MS. **Sponsor:** Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. **Fee:** \$15. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312-771-7000.

Introduction to CME Techniques

Two-day intensive workshop, Dec. 1-2. For: Hospital DME's, Program Chairmen, Medical Faculty, CME Planners. **Leaders:** Donald F. Pochly, M.D., and Leonard S. Stein, Ph.D. **Sponsor:** ICCME. Oak Brook Hyatt House, Oak Brook, IL. **Credit:** AMA and IL license Category 1, 14 hours. **Contact:** Diane Wolniewicz, ICCME, 55 E. Monroe, Chicago 60603. **Phone:** (312) 236-6110.

RECENT CME ACCREDITATION RECOMMENDATIONS

The ISMS Committee on CME Accreditation has recently recommended to Liaison Committee-CME approval of the CME programs of the following institutions.

Elgin Mental Health Center
Elgin

Highland Park Hospital
Highland Park

Illinois Heart Association
Springfield

Illinois Masonic Medical Center
Chicago

Illinois Thoracic Surgical Society
Chicago

Memorial Hospital of DuPage
County
Elmhurst

Riveredge Hospital
Forest Park

St. Elizabeth's Hospital
Chicago

St. Francis Hospital
Blue Island

SwedishAmerican Hospital
Rockford

ETHICAL ISSUES IN CRITICAL CARE

For: GP's. Lecture, Jan. 10, 2:00-5:00 p.m., Chicago. **Sponsor:** The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago 60637. **Fee:** \$20. **Reg. limit:** none. **CME Credit:** AMA Category 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Elaine Ehrman. **Phone:** 312-947-5777.

*Family Medicine***UPDATE—PRIMARY CARE MEDICINE**

For: GP's, FP's, Internists. Lectures, Jan. 5 & 26, 8:00 a.m., Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **CME Credit:** AMA Category 1, 2 hours. **Contact:** P. Colon. **Phone:** 312-883-2112.

*Family Therapy***PROBLEM-CENTERED SYSTEMS THERAPY—ASSESSMENT**

For: MD's. 2-day workshop, Jan. 18 & 19, 9:30 a.m.-4:30 p.m., Chicago. **Speaker:** William Pinsof, Ph.D. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsor:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Reg. limit:** 100. **CME Credit:** AMA Category 1, 12 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Family Therapy***PERSONAL/PROFESSIONAL GROWTH WORKSHOP FOR THERAPISTS: WITH OR WITHOUT PARTNERS**

For: MD's, therapists. Seminar, Jan. 25, 26, 27, Oak Park. **Speaker:** Charles Kramer, MD. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Reg. limit:** 16. **CME Credit:** AMA Category 1, 17 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Family Therapy***LAW IN THE EVERYDAY PRACTICE OF PSYCHOTHERAPY**

For: MD's. Workshop, Jan. 26 & 27, 9:30-4:30 p.m., Chicago. **Speaker:** Sandra Nye, JD, MSW. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Reg. limit:** 40. **CME Credit:** AMA Category 1, 12 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Forensic Medicine***REVIEW OF CURRENT FORENSIC PATHOLOGY CASES**

For: MD's, DDS's, LIB's. Workshop/lecture, Thursdays, 2:00 p.m., Chicago. **Sponsor:** Office of the Medical Examiner, Cook County, Illinois, 1828 W. Polk St., Chicago 60612. **Fee:** none. **Reg. limit:** 50. **Contact:** Robert Stein, MD. **Phone:** 312-443-5017.

*Medicine***14th ANNUAL MEETING**

For: FP's. Symposium/workshop, Jan. 14-19, Las Vegas, Nevada. **Speaker:** Michael De Bakey, MD. **Fee:** \$250. **Reg. limit:** none. **CME Credit:** AMA Category 1, 40 hours. **Sponsor:** American Society of Contemporary Medicine and Surgery, 6 No. Michigan Ave., Chicago 60602. **Contact:** John Bellows, MD. **Phone:** 312-236-4673.

*Ophthalmology***14th ANNUAL SCIENTIFIC ASSEMBLY**

For: Ophthalmologists. Seminars/lectures/workshops, Jan. 14-19, Las Vegas, Nevada. **Sponsor:** American Society of Contemporary Ophthalmology, 6 No. Michigan Ave., Chicago 60602. **Fee:** \$250. **Reg. limit:** none. **CME Credit:** AMA Category 1, 40 hours. **Contact:** John Bellows, MD. **Phone:** 312-236-4673.

*Ophthalmology***THE ROLE OF THE PRIMARY PHYSICIAN IN EYE CARE**

For: FP's, Internists, Pediatricians. Workshop, 3 sessions in 1979, Chicago. **Sponsor:** Dept. of Ophthalmology, University of Illinois, 1855 W. Taylor, Chicago 60612. **Fee:** \$200/session. **Reg. limit:** 40. **CME Credit:** AMA Category 1. **Contact:** Carmen Carrasco. **Phone:** 312-996-8023.

*Psychiatry/Psychology***NARCISSISTIC FACTORS IN PSYCHOTHERAPY**

For: MD's, Psychiatrists. Lecture, Jan. 17, 1:00-4:00 p.m., Forest Park. **Speaker:** Arnold Goldberg, MD. **Sponsor:** Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. **Fee:** \$15. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312-771-7000.

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IMJ

Illinois Medical Journal

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ISMS ORGANIZATION

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in book form presenting not only the minutes of the House of Delegates, but also all scientific papers

given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. Van Dellen was the editor for 18 years ending 1977. Subsequently, an Editorial Board was established to review and determine clinical content for the *IMJ*. The Editorial Board reports to the ISMS Publications Committee.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922, he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

Principles Of Medical Ethics

PREAMBLE: These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving

adequate notice. He should not solicit patients.

SECTION 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8—A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

ILLINOIS STATE MEDICAL SOCIETY

Constitution And Bylaws

Adopted, 1903
As Amended, 1978

CONSTITUTION

ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

ARTICLE VI. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, and such trustees and other officers as the Bylaws may provide.

ARTICLE VII. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

ARTICLE VIII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual or interim business meeting of the House of Delegates provided that the amendment shall have been proposed at a preceding annual or interim business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Associate members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular Members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principal-

ly in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

- B. *Associate Members.* Associate members are physicians who hold the degree of Doctor of Medicine, who have a hospital permit to practice medicine in the State of Illinois and are members of their component medical society.
- C. *Emeritus Members.* Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.
- D. *Retired Members.* Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.
- E. *Service Members.* Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.
- F. *Distinguished Members.* Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.
- G. *In-Training Members.* In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.
- H. *Student Members.* Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

Section 2. *Discrimination of Membership.* Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

Section 3. *Tenure and Termination.*

A. *Tenure of Membership.* The name of a physician on

a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this society. The member shall retain his membership so long as he complies with the provisions of this Constitution and Bylaws and with the Principles of Medical Ethics of the American Medical Association. A member shall hold only one type of membership at any one time.

B. *Termination of Membership.* Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Suspension will in no way affect insurance benefits.

A member whose dues are unpaid by March 31 of the current year ceases to be in good standing and shall be notified of his delinquency by the secretary. A member whose dues or assessments remain unpaid on April 30 of the current year shall automatically be dropped from membership. An individual who has forfeited membership for non-payment of dues or assessments may be reinstated as a member before two years have elapsed, providing, in the interim, he has not been guilty of conduct prejudicial to membership, by the full payment of all dues or assessments in arrears from the date that he was last in good standing. If two or more years have elapsed since he was a member in good standing, he will be required to make application as a new member.

Any member in good standing who resigns voluntarily by December 31 of any year may be reinstated within one year of his resignation by paying all dues and assessments that fell due during the period that his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. Any past member who regains membership by payment of all dues and assessments in arrears shall be eligible for membership benefits only to the extent and in the same manner as a new member initially joining the society.

CHAPTER II. DUES, FUNDS AND ASSESSMENTS

Section 1. *Dues.* Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal*. Only Regular, Associate, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

Section 2. *Reduction and Remission of Dues.* Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. *Assessments and Funds.* In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

CHAPTER III.

EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, and 8) one delegate elected by the Resident Physicians Section and one delegate elected by the Student Business Session.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, and one representative from each member organization of the Council on Affiliate Societies.

Section 2. *Delegates.* Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates.* There shall be a Resident Physicians Section and a Student Business Session, which shall be open, respectively, to all in-training and medical student members of ISMS. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. *Time and Place of Meeting.* The House of Delegates shall meet twice each year. These two meetings shall be designated as the annual meeting and the interim meeting. The time and place of both shall be as the House determines, except that the interim meeting should not exceed three days and it should be held in a district other than where the annual meeting is held.

Section 5. *Quorum.* Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special meetings.* Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days

before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President and/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure.* The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor.* The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. *Introduction of Resolutions and Other Business.* All resolutions must be introduced by a voting member of the House. Resolutions submitted nine weeks prior to the annual or interim meeting of the House will be listed in the delegates handbook citing author and subject only; a full copy of all resolutions will be mailed to the delegates. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be received at ISMS headquarters four weeks prior to the annual or interim meeting. Resolutions received after the above date except those originating from the RPS or SBS business sessions, must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. Resolutions presented from the business meeting of the Resident Physician Section or the Student Business Session may be presented for consideration by the House of Delegates at any time before the close of business of the first day session of the House of Delegates.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

CHAPTER V. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

Section 2. *The President-Elect.* The president-elect shall serve as the chairman of the Committee on Planning and Priorities.

Section 3. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the second vice president will become first vice president.

Section 4. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. *The Speaker.* The speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

Section 8. *Delegates and Alternate Delegates to the American Medical Association.* Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies established by the ISMS House of Delegates as they pertain to the AMA activities.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of: twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon, Tazewell.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—Counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall, Will.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

Section 2. *Duties.* The duties of the Board of Trustees are executive, custodial and judicial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before the House of Delegates or the general scientific meetings, shall be referred to the Board of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

Section 6. *Quorum.* Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publication.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from

the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1. *Committee Structure.* The committee structure of the Illinois State Medical Society shall be as follows:

- A. Councils (standing committees)
- B. House of Delegates Committees
- C. Board of Trustees Committees
- D. Ethical Relations Committee (Chapter XI of these Bylaws)

Section 2. *Councils.*

A. The Medical-Legal Council shall be concerned in the areas of:

1. Liaison with the Illinois Bar Association
 2. Liaison with courts, particularly where impartial medical testimony is involved.
 3. Implementation of the Impartial Medical Testimony Rule
 4. Legal aspects of medical practice other than in the area of mental health
 5. Licensing and standards of practice.
 6. Quackery
 7. Anatomical gifts and organ transplants
- B. The Council on Governmental Affairs shall be concerned in the areas of:
1. Federal and state legislation—analysis and communication
 2. Legislative liaison—both state and federal
 3. Political education
- C. The Council on Education and Manpower shall be concerned in the areas of:
1. Liaison with medical schools, curricula, etc.
 2. Health manpower and training
 3. Internships, residencies, etc.
 4. Scientific assembly
 5. Student loans
 6. Liaison with American Medical Student Association
 7. Continuing Medical Education
- D. The Council on Economics and Peer Review shall be concerned in the areas of:
1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)
 2. Relations with prepayment, insurance and other third party plans.
 3. Fees and fee adjudication
 4. Health care cost and utilization
 5. Peer Review (Part 2 of Chapter XII of these Bylaws)
- E. The Council on Medical Service shall be concerned in the areas of social and medical services and in environmental and community health.
- F. The Council on Public Relations and Membership Services shall be concerned in the areas of:
1. Publicity and promotion
 2. News media relations
 3. Exhibits and public service programming
 4. Religion and medicine
 5. New member orientation and membership benefit explanation
- G. The Council on Mental Health and Addiction shall be concerned in the areas of:
1. Facilities and services
 2. Liaison with Department of Mental Health
 3. Legal aspects of commitment, etc.
 4. Narcotics and dangerous drugs
 5. Alcoholism
- H. The Council on Affiliate Societies shall be concerned in the areas of:
1. Liaison between the affiliate society and ISMS.
 2. Scientific resource information and advice to ISMS.
 3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity, legislation.
 4. Advances of medical science in special fields.

- I. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as the chairman of the committee.

Section 3. Organization of Councils.

- A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.
- B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

- C. Members of the Illinois State Medical Society (who are not voting members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by Illinois Chapters of the American Medical Student Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with the permission of the House of Delegates) the right to speak on the floor of the House, but to have no vote out of committee. Voting members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

- D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.
- E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.
- F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

- G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

- H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

- I. Reports of subcommittees shall be made by the chairman to the council under which they are operating. Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

J. Affiliate Societies

1. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois
 - a) as may be approved by the Board of Trustees
 - b) which desire representation on the Council on Affiliate Societies
2. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

Section 4. House of Delegates Committees. House of Delegates Committees of the Illinois State Medical Society shall be as follows:

- A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.
- B. Committee on Rules and Order of Business shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.
- C. Committee on Tellers and Sergeants-at-Arms shall:
 1. Serve the speaker of the House of Delegates.
 2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
 3. Certify those in attendance in closed or executive sessions of the House of Delegates.
- D. Committee on Changes in the Constitution and Bylaws shall consider all proposed amendments to the Con-

stitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

- E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.
- F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 5. *Organization of House of Delegates Committees.*

- A. Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates. Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.
- B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.
- C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 6. *Board of Trustees Committees.* The Board of Trustees shall form the following committees within itself:

- A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. If the immediate past-chairman of the Board is no longer a trustee, the chairman of the Policy Committee shall be a mem-

ber of the Executive Committee. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

- B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence to determine eligibility for assistance;
 2. Keep the names of the beneficiaries confidential and known only to the committee;
 3. Recommend the allotment for each recipient; and
 4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.
- C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.
 - D. The Ethical Relations Committee shall be constituted and function as stipulated in Chapter XI, Discipline, Part 2, Illinois State Medical Society procedures.
 - E. The Committee on Constitution and Bylaws shall consist of five members, the Speaker of the House and four members appointed by the Chairman of the Board. It shall:
 1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
 2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
 3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.
 - F. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall

be responsible for the production of the *Illinois Medical Journal*.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal*.

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

G. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

H. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 7. *Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 8. *Term of Membership.* The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward an annual report consisting of a roster of members as of December 31 of the preceding year and a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics

of the American Medical Association, shall be binding upon members of the component societies.

CHAPTER XI. DISCIPLINE

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Ethical Relations Committee.* Each component society may have, either by appointment or election, an Ethical Relations Committee, whose duty it shall be to prosecute formal charges of unethical conduct. In the event that the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

All parties may have legal counsel present to advise and counsel them during the proceedings, but such counsel may not participate in the proceedings, and may be excluded from the hearing by the chairman or by vote of the committee.

The component society Ethical Relations Committee may establish reasonable rules of procedure, and they shall not be bound by the technical rules of evidence as the same pertain in courts of law. In all proceedings before such Ethical Relations Committees, the complainant, the accused and all witnesses before the committee shall be placed under oath.

The Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 2. *Offenses.* Any member of a component society shall be subject to censure, suspension or expulsion by such component society when:

- A. He has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or
- B. He has been adjudged guilty by his component society in accordance with the procedural requirement of these bylaws:
 1. of a gross misconduct as a physician, or
 2. of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Formal Written Charges Presented to the Illinois State Medical Society.* Formal, written charges received by the Illinois State Medical Society shall be referred directly to the secretary of the component society of which the charged individual is a member or to the district Ethical Relations Committee in the event that the component society does not have an Ethical Relations Committee.

Section 4. *Principles of Justice.* The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

- A. A charged individual is presumed to be innocent until he has been proven guilty.
- B. No proceeding shall be initiated under this Part I until formal written charges have been filed with the secretary of the component society or the district Ethical

Relations Committee, as the case may be. Thereafter, said formal written charges must be presented under oath or affirmation by the complaining party before the Ethical Relations Committee of the component society or the district Ethical Relations Committee, as the case may be.

- C. A hearing shall be held by the committee within 30 days after the formal written charges have been filed, unless continued by the chairman of the committee upon good cause shown.
- D. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold the hearing within the time period, including reasonably granted continuances, either the complaining party or the physician, against whom formal written charges have been brought, may appeal for relief and hearing to the district Ethical Relations Committee, which will determine the reasonableness of the effort.
- E. The individual against whom formal charges have been filed shall be sent a copy of said charges by certified mail at least 10 days before the date set for the hearing, together with a statement of the rights of the charged individual as follows:
 1. to be represented by any member of the society as counsel and that he may have legal counsel present;
 2. to cross-examine witnesses;
 3. to offer in evidence any pertinent records or documents;
 4. to object to any testimony or exhibits offered in evidence;
 5. to address the hearing body in his own behalf;
 6. to be tried only on the specific charges filed;
 7. to have stricken from the record any improper testimony or exhibits;
 8. to appeal to the Board of Trustees of the Illinois State Medical Society.

Section 5. *Records.* A comprehensive stenographic record, tape recording or its equivalent of the entire proceedings, together with all exhibits, must be kept for reference, and shall be available until final adjudication has been made.

In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record, tape recording or its equivalent, of the entire proceedings shall be forwarded by certified mail to the Board of Trustees of the ISMS at least ten days prior to the date the appeal is to be heard.

If the component society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the charged individual not guilty.

Section 6. *Verdict.* The committee, sitting as a hearing body, shall recommend the charged individual be found either guilty or not guilty. If the verdict is guilty, the hearing body shall recommend censure, suspension or expulsion.

The findings of the hearing body must be presented to the component county society for approval or rejection. The charged individual must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the component society are against the charged individual, the secretary of the component society shall acquaint the charged individual by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. *Illinois State Medical Society Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

Section 2. *Appeals from Component Society Verdicts.* Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must be accompanied by a comprehensive stenographic record tape recording or its equivalent, of the entire proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of the Illinois State Medical Society shall find the accused "not guilty"). The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. *Verdict.* The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. *Notification and right of appeal.* The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

CHAPTER XII. PEER REVIEW

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Peer Review Committee.* Each component Society shall have, either by appointment or election, a Peer Review Committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients, institutions, insurance carriers, or government agencies.

The district peer review committee shall function and operate on behalf of any county society which does not establish such a committee.

Section 2. The committee shall consist of a chairman and such members representing the various specialties, including family practice, as each individual county society shall determine. Such committee should have access to counsel from each of the various medical specialties. The component county society may establish reasonable rules of procedure but shall not be bound by the technical rules of evidence as the same pertains in courts of law. All proper complaints shall be reduced to writing and shall be signed by the individual making the complaint.

Section 3. Original complaints received by the Illinois State Medical Society shall be referred to the proper county society or to the district committee.

Section 4. The Peer Review Committee shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 5. The Peer Review Committee shall initiate consideration of all complaints and matters filed with it within 60 days from the date of filing and shall render an opinion within 30 days after the conclusion of the hearing. In the event the committee does not follow this procedure any party may appeal for relief to the proper district committee whose procedure shall be the same as is set forth herein for county societies.

Section 6. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings in writing to all parties involved. In the event the investigation and study of the committee results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing to the component society.

Section 7. In its study and deliberations the Peer Review Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 8. Any party to the proceedings considering himself aggrieved by the findings and recommendations of the committee shall have the right to appeal through the component society to the Illinois State Medical Society.

Section 9. In the event of an appeal to the Illinois State Medical Society, the county society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the opinions of the county or district committee. Any appeal hereunder shall be filed with the Illinois State Medical Society within 30 days after the final opinion of the county or district committee has been rendered.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. All appeals received by the Illinois State Medical Society shall be referred to the Council on Economics and Peer Review, which shall review opinions of the county or district peer review committee. The council shall have the power to counsel with and obtain information from medical specialists when appropriate. The Council shall have the power to review both the procedural and substantive aspects of any appeal before it.

Section 2. The council upon receiving notice of an ap-

peal shall set the matter for hearing within 30 days after the appeal has been filed and at such hearing shall review the record sent to it from the county society or district society, receive additional pertinent evidence any interested party desires to offer and render its conclusions and findings in writing, copies of which shall be mailed to all interested parties. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings to all parties involved. The conclusions and findings shall be advisory only.

Section 3. The Council on Economics and Peer Review of the Illinois State Medical Society shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 4. In the event the investigation and study of the Council results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, of the Illinois State Medical Society, or of the Principles of Medical Ethics

promulgated from time to time by the American Medical Association, the matter shall be referred in writing back to the component society.

CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

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1978-1979

Policy Manual

of the

Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

- (1) approve, amend, or reject—
- (2) refer the statement to the Board for reconsideration and subsequent report—
- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

PROFESSIONAL POLICIES

Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Performance of abortions should be carried out in accordance with current guidelines as promulgated by the House of Delegates. If not in conflict with state and federal law, an abortion so performed shall not be considered unethical. No physician shall be required to perform or participate in an abortion.

Acupuncture

Acupuncture is a surgical procedure and its practice should be limited to physicians licensed to practice medicine in all of its branches and to dentists.

Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational and/or social adjustments as a direct consequence of persistent and excessive use of alcohol.

Insurance companies are encouraged to include appropriate coverage for alcoholism in health insurance policies similar to coverage for any other illness and general hospitals, both public and private, are encouraged to accept alcoholic patients (both in-patient and out-patient) for detoxification and rehabilitation.

Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that mental health clinics should enlarge their services to include treatment and counseling of alcoholics and their families and, where appropriate, collaborate with Alcoholics Anonymous as well as half-way houses; that education programs aimed at alcohol abusers who are drivers should be encouraged and legal restrictions established to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects should be encouraged.

Ambulance Services

All ambulance services should meet minimum standards as developed from time to time by the Illinois State Medical Society and the State of Illinois.

Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

Audits & Surveys

(Hospital, nursing homes, etc.)

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned.

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.

Blood Procurement

Inasmuch as blood procurement affects the entire community, any blood procurement program should be carried out only with the approval of the local county medical society involved.

Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

Community Health Week

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities during the winter or spring of the year.

Comprehensive Health Planning

Upgrading of local health facilities should be implemented through Comprehensive Health Planning on a home rule basis rather than through metropolitan oriented advisory services. Where a county medical society is unable to enter into meaningful participation in areawide health services planning, this function may be assumed by an appropriate ISMS District Committee or, where the appropriate District Committee is unable to act, by the Illinois State Medical Society.

Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileges must be continued in accomplishment of the treatment of human illness. Section 9 of the Principles of Medical Ethics states that "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of the confidentiality of the doctor-patient relationship as it relates to the ambulatory patient record and will take an active role in uncovering any violation of the doctor-patient confidential relationship by officials and personnel of review organizations and will take whatever steps are necessary to eliminate the breach of confidence.

ISMS is in total opposition to the use of the Social Security number as a universal number identifier.

Conflict of Interest

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.

Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multi-faceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

ISMS should continue to support the efforts of county medical societies in becoming certified for sponsoring continuing medical education programs meeting the requirements promulgated by the Liaison Committee on Continuing Medical Education and the regulations of the State of Illinois.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

In the certification of educational quality of continuing medical education programs, the Illinois State Medical Society should have a primary role. Physicians should be encouraged to participate in self-assessment test programs prior to registering for such hospital courses and other learning activities.

Sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses.

Cultists, Association with

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians.

Death, Legal Definition of

ISMS will not support any legislative proposal which seeks to define death unless it provides that, based upon usual and reasonable standards of medical practice, death has occurred when it is determined by a doctor of medicine that a person has experienced the permanent and irreversible cessation of the integrated functioning of the respiratory, circulatory and nervous system, according to the following standards:

- (a) the irreversible cessation of spontaneous respiratory and circulatory functions; or
- (b) if artificial means of support preclude reliance on item (a), the irreversible cessation of spontaneous brain function, which may be confirmed by a flat (isoelectric) electroencephalographic tracing in the absence of hypothermia and of barbiturate and other nervous system depressants.

Death With Dignity

The Illinois State Medical Society will continue to oppose death with dignity, right-to-die and similar legisla-

tion, based on what must necessarily be a private matter between physician and patient.

Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

Discrimination—(see "Freedom of Choice")

Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Substitution of prescribed drugs by pharmacists is opposed, except in cases of extreme emergency, unless there be full explanation and agreement by both the patient and the doctor.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.

Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.

Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.

Experimental Medical Procedures

In order to conform to the ethics of the American Medical Association, three requirements must be satisfied

in connection with the use of experimental drugs or procedures:

1. The voluntary consent of the person on whom the experiment is to be performed should be obtained.
2. The danger of each experiment must be previously investigated by animal experimentation.
3. The experiment must be performed under proper medical protection and management.

Eyes

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or use eye medications; only such physicians should continue to be the primary entry-point for eye care. ISMS will vigorously oppose any attempt in Illinois to give optometrists a license to prescribe or use medications or to serve as a primary entry-point in the provision of eye care.

Fee Schedules

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees. Fees should be commensurate with services rendered.

Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost.

The Illinois Foundation for Medical Care is completely accountable only to the House of Delegates, through the Board of Trustees of ISMS, and to each component society of ISMS.

Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

The Illinois Foundation for Medical Care is authorized to investigate and, if economically feasible, to implement programs for supporting physician organizations endorsed by constituent medical societies. Such support is to be in the areas of data needs and other specialized activities, such as statewide co-ordination, statistical analysis, co-ordinated negotiations and support of related state level organizations, utilizing public, governmental or private funds to reimburse the foundation for such activities. Specifically, the IFMC Board is authorized to investigate the feasibility of becoming a statewide support center for physician organizations endorsed by constituent medical societies and to provide administrative support, data processing and specialized services to such physician organizations.

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be main-

tained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

ISMS supports the concept of second opinion—only via the usual and customary referral pathways guaranteeing the free choice of physicians.

Governmentally Supported Health Facilities

ISMS should not facilitate the development of governmentally-supported Health Maintenance Organizations or similar practice alternatives which would be discriminatory against the private or group practice of medicine.

Health Care—Ancillary Services

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, problems of migrant workers, etc., and any other area which involves the health of the people of this state.)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees and reaffirms its faith in the private enterprise system which has made the United States great and strong and which seeks to make health care available to everybody.

The Illinois State Medical Society encourages cost sharing by patients in all medical care reimbursement plans.

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which

quality of care is compromised.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs of psychologists, social workers or any group of individual practitioners without medical supervision.

Health Insurance, Voluntary Plans

ISMS endorses the principle of voluntary health insurance. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

The Illinois State Medical Society supports the concept of increased insurance coverage for out-patient diagnostic tests.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

- Implying to patients that physician's charges above insurance benefit allowances are excessive;

- Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;

- Suggesting that physicians perform alternative surgical procedures;

- Instituting utilization review of hospital patients in the private sector which by-passes local physician review mechanisms;

- Discriminating against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

ISMS endorses long-held principles that:

- A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and

- The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

Health Screening by Paramedical Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.

Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.

Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

All county medical societies are encouraged to form standing committees composed of medical society officers and representative officers of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations, governmental and quasi-governmental agencies in their community.

The Illinois State Medical Society encourages the development of local peer review plans for appropriate review of utilization of hospital emergency rooms.

Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on a medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of a hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Results of recertification examinations should not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges.

Hospital Records and Their Availability

Patient care hospital records contain privileged information of confidential nature. Such records are the property of the hospital; information contained therein is held in trust, through a fiduciary relationship, by the hospital.

Patients, and upon appropriate, written authorization, their attorney or succeeding physician, have the right of access to these records, with the ability of review and the right to copy or receive copies. This access is not afforded to patients in cases of psychiatric illness.

Upon receipt of proper, written authorization from the patient, a copy, abstract or summary shall be provided as required, to insurance companies, governmental agencies, or other hospitals.

Patient records utilized by official committees of organized medical staffs to accomplish scientific studies of morbidity or mortality, utilization review, peer review or other patient care improvement activity remain confidential and shall not be disclosed to any person outside the purview of such committees.

Where litigation is involved, a physician may be required to release medical records in the absence of a signed patient authorization. In those instances, a physician should ascertain that he is required to release the medical records and that the agent so requiring the release has the appropriate authority.

Hospital Staff Assessments

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection, especially to all children, or to encourage the local public health agency to perform this function.

Every school district should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

County medical societies should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.

Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.

Medical Care, Provision of

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

Medical Diagnosis and Treatment

Third parties, including government personnel, insurance carriers, review organizations and hospital personnel should be informed and educated that the Illinois State Medical Society endorses the concept that prognosis and length of treatment must always be individualized to the patient, rather than to the diagnosis.

Medical Education

The Illinois State Medical Society supports development of innovative curricular and co-curricular programs in medical education maintaining a firm foundation in the basic sciences.

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coronor system, wherever practical.

Medical Psychotherapy

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches, who has had training in psychiatric medicine.

Medical Testimony, Expert Witnesses

An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, current personal experience, practical familiarity, and technical knowledge of the problems that are

being considered, as well as alternative forms of treatment, and is currently active in the practice of the medical subject under discussion.

Any physician licensed to practice medicine in all its branches who functions as an expert witness must satisfy the definition of an expert witness, that the definition be a matter of policy, and that it be considered unethical conduct on the part of any physician appearing as an expert witness who does not meet this standard.

Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to give testimony. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

Mental Health

The Illinois State Medical Society strongly opposes the double standard of care in state hospitals and favors elimination of permit physicians (unlicensed physicians practicing in state institutions). Every effort should be made to extend educational opportunities to these permit physicians to enable them to achieve full licensure.

In addition, the Department of Mental Health and Developmental Disabilities should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating state funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

Each constituent county society should cooperate fully with and support local units of the Department of Mental Health in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, i.e., crisis intervention, to be available areawide.

All physician or other health service provided to the Department of Mental Health, other than that by full-time employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

Involuntary psychiatric hospital certification, initial or subsequent, must without exception remain the responsibility of a physician licensed to practice medicine in all of its branches, and a physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

Minors, Medical Treatment of

Where parental consent is not legally required for medical treatment of minors, the physician's judgment

shall prevail as to whether or not the parents should be notified of such treatment.

Multiphasic Screening

Automated multiphasic health testing and screening laboratories are recognized as an extension of services available to the physician for the health needs of individual patients. A position statement on multiphasic health testing, developed by the ISMS Council on Environmental and Community Health, and the American Medical Association Guidelines for establishing and operating such programs are attached as an appendix to the Policy Manual.

Nurses—Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.

Nutrition

Prophylactic use of iron fortified foods is approved in accordance with a 7-point statement developed by the Nutrition Committee and the Council on Environmental and Community Health in 1971.

Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of industrial physicians.

Optometric Services

ISMS supports the concept that those performing optometric services in Veterans Administration facilities should be directly responsible to their respective departments of ophthalmology.

Osteopaths, Association with

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

Peer Review

Peer review is the evaluation by practicing physicians of the quality, appropriateness and efficiency of services

ordered or performed by other practicing physicians. It is the all-inclusive term for medical review efforts, including utilization review, quality of care, competence determination and ethical considerations.

Medical society peer review shall be conducted at the local level whenever possible.

Physician-Patient Relationship

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

Physicians

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches." The goal of the Illinois State Medical Society is to have this definition made a part of the Illinois Medical Practice Act.

Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Such plans should recognize that free standing medical and surgical facilities are acceptable methods of delivering high quality health care. Reimbursement for expenses incurred as an outpatient in such facilities should be included in the benefits of these plans.

ISMS is opposed to any legislation which mandates insurance benefits for medical care of psychiatric illness into an optional status.

Prolonging Human Life

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.

Psychosurgery

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery

should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and co-operating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be based upon the usual and customary fee concept.

An extensive program of education should be conducted for the recipients of public aid. This should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

Local public health service jurisdictions should be consolidated into sufficiently large geographic and population districts to achieve program efficiency.

Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

Relative Value

The Relative Value Study is not a fee schedule and is to be used for information only. All fee payments should be based on the usual, customary and reasonable concept.

No co-efficient shall be established at the state level. The

data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon recommendation of the Relative Value Committee with approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

Smoking

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco smoke-free.

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable. Representatives to serve in this capacity may be nominated by the specialty society, approved by the Board of Trustees of ISMS, and designated as consultants to the council without vote, in compliance with the Bylaws.

Third Party Intrusion Into Medical Judgment

Medical judgment and decision-making power of the

treating physician must not be abrogated by third party payors. ISMS is opposed to any third party having the power of decision as to medical necessity of services and supplies, including hospitalization, over and above the judgment of the treating physician.

Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

Violence

The Illinois State Medical Society opposes the ready accessibility to hand guns without evidence of responsibility on the part of the possessor and urges strict enforcement of present federal, state and city laws and that the courts, as well as the legislature, impose maximum penalties on all offenders.

The Illinois State Medical Society will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including the offering of rewards and other incentives in the solution of such cases.

ADMINISTRATIVE POLICIES

AMA-ERF

The Illinois State Medical Society's dues billing form shall include the names of all medical schools in Illinois so that every member may designate which school is to receive his AMA-ERF contribution.

Assessments

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

Autonomy of County Medical Societies

In all areas, the county medical society shall be autonomous, except that no ruling by any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association or with the Constitution and Bylaws of the Illinois State Medical Society.

Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Physicians appointed to an Illinois State Medical Society committee must be members in good standing of this Society.

Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

Co-operation with the American Medical Association

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

Dues, Recommendation of the Board to the House

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration by the Board of Trustees in time for the Board to present its recommendations to the House of Delegates each year.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the *Illinois Medical Journal* as a part of the annual report of the Chairman of the Board.

Education, Primary and Secondary

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

Election of AMA Delegates

Delegates to the American Medical Association should almost without exception be elected from those having served first as alternate delegates.

Facility Medical Boards (Physicians)

In all legislation which establishes boards for the administration of medical facilities operated by governmental units, at least one-third of the board should be physicians licensed to practice medicine in all its branches.

Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for election as AMA officers, trustees or members of councils or

committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

Honoraria For Officers

The Finance Committee is instructed to evaluate annually the honoraria paid to ISMS officers and to recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.

House of Delegates, Special Meetings of

When a special meeting of the House of Delegates is scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

Informing the Membership

The membership of the Illinois State Medical Society shall have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal*;
2. Brief notice in Action Report, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils and committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except in situations wherein positions suddenly become open, and such consultation is impossible.

Journal Publications

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the *Illinois Medical Journal*.

Lay Employees' Functions

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

change existing policy

establish new policy

request House approval of committee projects and/or procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

Legislation

All matters pertaining to state or federal legislation shall be referred to the Governmental Affairs Council for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Governmental Affairs of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any Council or Committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House Committees in support of, or in opposition to, the legislation recommended by the Council or Committee.

Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.

Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Unless physicians appointed to the boards and committees of other organizations, such as local Comprehensive Health Planning "b" agencies, are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.

Medical Schools

The Illinois State Medical Society favors admission of students into medical schools on the basis of their ability to be good medical students and physicians.

Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

Membership of Osteopathic Physicians in ISMS

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA, and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain

physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

Policy Statements

Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.

Press

All county medical societies should be encouraged to cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians including the right of individual physicians to appear before appropriate peer review committees responsible for his liability insurance coverage.

The Illinois State Medical Society should protect the interests of its members by encouraging the provision of a guarantee of due process in the bylaws of the Illinois State Medical Inter-Insurance Exchange.

Public Statements

Only officially designated persons may publicly speak for the society. The Chairman of the Board of Trustees, at the request of the President, shall designate ISMS spokesmen.

Spokesmen should bear in mind that, as representatives of the Society, they should refrain from expressing their

personal views. Their public statements should be—to the best of their ability—in consonance with the Society's policies and positions.

Publication of Research Data

In releasing research material for publication in the *Illinois Medical Journal*, or any other media, extreme care should be exercised. The welfare and privacy of the patient, and the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

Rebates

In conformity with the AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical. This statement on rebates was developed as a result of a letter regarding collection services. It read in part:

"It is our policy to remit to a participating association the sum of 10 per cent of the gross book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

Resolutions

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS.

Stationery, Use of Official

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

Surveys

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.

Policy Manual

APPENDIX

Multiphasic Health Testing Council on Environmental and Community Health Statement

During the recent past there has been an upwelling of various automated or multiphasic health testing or screening programs. The use of the results of such testing has at times led to a false sense of security on the part of patients, whereas other programs are being foisted on the public with the view to making money with very little concern for an individual's well being. Other programs are offered as having direct, immediate and practical medical value, without review by a physician. These many concerns prompt the necessity of a position statement on the use and application of such programs.

There is a place for computer and automated multiphasic testing and screening programs as an extension of the services available to the physician as he considers each individual case. It is entirely possible that such a mechanism will enable a physician to expand his scope of operation.

Forms of automated multiphasic health testing have been used by public health agencies and centers for developmental research in epidemiology. In these programs, asymptomatic control patients have been tested. Testings have been done to establish medical priorities or case findings in communities. Other testing has been done to separate those who probably have certain characteristics from those who do not.

Occupational or industrial health programs have used testing programs for the betterment of employees' health and working conditions. Programs such as these, whether a pre-employment examination or a study to control health hazards, are not necessarily related to medical care as such. The physician in charge may or may not at the same time be the attending physician of the employee.

As far as automated multiphasic health testing programs for individuals are concerned, these programs obtain health-related data and act as data collecting sources, following a routine using technicians or mechanical and electronic devices to determine facts. In several hours a variety of tests and measurements can be made which may provide a profile of an individual's physical status. Such a profile can be of value to a physician. The testing is not diagnosis or interpretation.

Some individually oriented automated multiphasic health testing programs are operated commercially on a for-profit basis. Many of these do determine and report

facts accurately. Some, however, give the appearance of encouraging individuals to be tested without a medical referral for the tests. Some indicate that when the results are compared against standards or norms the individual does not even have to see a physician. Some, in addition, perform a battery of tests which are not requested by an attending physician.

The physician's ethical responsibility is to provide his patient with high quality services. He should not utilize services of any testing program unless he has the utmost confidence in the quality of its services. He must assume professional responsibility for the best interest of the patient. As a professional man, the physician is entitled to compensation for his services. However, he should not be engaged in the commercial conduct of a testing or screening program and should not make a mark up commission or profit on services rendered by others. It is not, in itself, unethical for a physician to own an automated multiphasic facility or interest. The use the physician makes of this ownership may be unethical.

An attending physician may not receive a rebate, referral fee, or commission from a program whose facilities have been used by his patients.

An automated health testing facility is a fact finding and reporting system. It must be limited to fact finding and exclude interpretation. Findings disclosed must be interpreted only by physicians.

Offering a combination of medical and non-medical service to the public is to be avoided. The public may be confused as to what constitutes reporting a fact and what constitutes the making of a medical diagnosis.

A practicing physician may recommend multiphasic health testing where he believes it may be helpful to him in the care of his patient. Prudence dictates that the physician be selective in recommending or requiring patients to utilize the services of an automatic health testing facility and not adopt the practice of routinely requiring that all patients, or all new patients, undergo such testing. When good medical judgment suggests the desirability of such testing, the physician should explain in general the nature and purpose of the testing. The patient must be afforded freedom to choose between automated multiphasic health testing facilities, if available. Alternatives in the way of single tests should be offered patients, where possible and practical.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the services of that physician by an agency for fee, nor allow his name

or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. He should neither aid nor abet an unlicensed individual or corporation to practice medicine.

There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

AMA Guidelines for Establishing and Operating Multiphasic Health Testing Programs

The following guidelines are recommended for use by physicians and medical societies in providing technical advice and assistance in the planning, development, implementation, and operation of multiphasic health testing programs:

1. Multiphasic health testing is a method of acquiring, storing, collating, and reproducing medical data on individual patients. The testing procedures are considered to be incomplete health services. Provisions must be made for a physician to interpret and evaluate this medical data base as an aid in continuing patient care.
2. The multiphasic testing program should meet applicable licensing requirements and be appropriately evaluated for quality control.
3. Physicians must be involved in the planning and development of testing programs.
4. The operation of all MHT programs must be supervised by qualified physicians at the testing center, particularly in regard to any abnormal findings, and these physicians must see that the patient is instructed to obtain medical advice for significant abnormal findings.
5. The system should be designed to make maximum use of allied health professionals and should utilize technical and automated techniques where justified.
6. For professional value and economic feasibility, the program should include tests that are simple, safe, easy to interpret, inexpensive and quick to perform,

and that have acceptable sensitivity, specificity, high predictive value, and patient acceptance.

7. The testing system should include the following criteria: reliability, accuracy of output, saving of time of physicians and allied health personnel, adequate utilization, and sufficient flexibility for customization to physician and patient needs. The program should establish individual ethnic, geographic, and other variations of normal and abnormal patterns.
8. The program should provide for confidentiality of patient data.
9. The testing program should be used, where feasible, to meet otherwise unmet community health needs and should be integrated into the continuing health care system.
10. The testing program should be designed to meet various objectives such as diagnostic services, health maintenance, and guidance in management of ongoing illness including chronic disease.
11. Evaluation methodology should be built into the program to determine the acceptance and use, yield, false positives and false negatives, as well as the long-term effects of the program on illness and the need and demand for health services. The program should include a documented accounting system, at least for internal use, and a reasonable cost finding system that would allow for cost analysis and cost summaries.
12. The program should maintain freedom of choice for both the physician and the patient.

Statement of Understanding (between patient and physician)

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government, or the like). Neither my doctor nor I will permit any third

party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.

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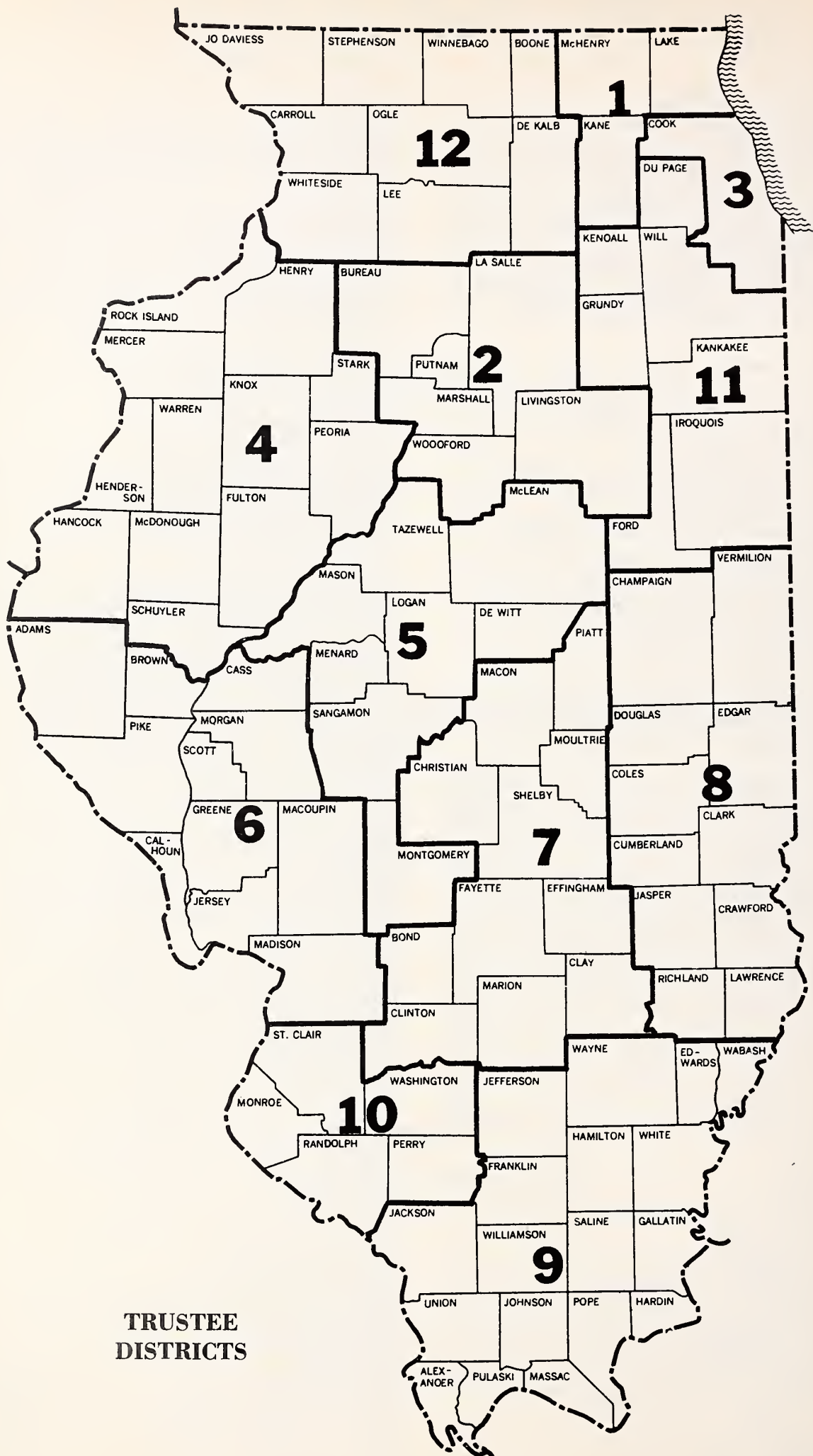
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A complete listing of delegates and alternates to the ISMS House appears in the convention program.

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Edward W. Cannady, Belleville1964-1967
Maurice M. Hoeltgen, Chicago1967-1970
James A. McDonald, Geneva1976-1977
Paul W. Sunderland, Gibson City1970-1973



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TERM
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Emanuel Herzon, Elgin1981
Gerald Liesen, St. Charles1979
A. M. Rosetti, McHenry1980
PEER REVIEW COMMITTEE
David Helberg, Waukegan, *Chairman*1981
Eugene Pitts, Waukegan1981
James Pritchard, Geneva1981
Peter Vinceguerra, Libertyville1981

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Allan L. Goslin, Streator, *Trustee*
Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford

ETHICAL RELATIONS COMMITTEE
TERM
EXPIRES

William Erkonen, Streator, *Chairman*1980
Julius Kowalski, Princeton1980
Karl T. Deterding, Pontiac1980

PEER REVIEW COMMITTEE

Louis Tarsinos, Princeton, *Chairman*1979
James B. Aplington, LaSalle1979
Francis J. Brennan, Utica1979
Silvio Davito, Spring Valley1979
Bernard J. Doyle, LaSalle1979
William Ehling, Streator1980
P. Lymberopoulos, Princeton1979
Rowland Musick, Mendota1979
Theodore Mauer, Chatsworth1981
Theodore W. Wagenknecht, Streator1979

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ETHICAL RELATIONS COMMITTEE

TERM
EXPIRES

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John Bowman, Abingdon1979
George Burke, Rock Island1981

PEER REVIEW COMMITTEE

Donald Dexter, Macomb, *Chairman*1980
William Daugherty, Moline1981
Jackson K. Erffmeyer, Galesburg1979
G. W. Giebelhausen, Peoria1981
James C. Parsons, Geneseo1979
Clarence Ward, Peoria1981

Fifth District

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ETHICAL RELATIONS COMMITTEE
TERM
EXPIRES

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Jack Means, Mason City1981
A. L. Van Ness, Bloomington1979

PEER REVIEW COMMITTEE

James Borgerson, Mt. Pulaski, *Chairman*1980
Robert Price, Bloomington, *Co-Chairman*1980
George Irwin, Bloomington1979
Paul Lafata, Springfield1980
Alton J. Morris, Springfield1979
Robert B. Perry, Lincoln1979
James Weimer, Pekin1979

Sixth District

Robert R. Hartman, Jacksonville, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin, Madison, Morgan, Pike, Scott

ETHICAL RELATIONS COMMITTEE
TERM
EXPIRES

Newton DuPuy, Quincy, *Chairman*1980
Bernard Baalman, Hardin1981
Edward K. DuVivier, Alton1980
Joseph J. Grandone, Gillespie1980
C. B. Lara, Pittsfield1981
Robert Roy, Jacksonville1981

PEER REVIEW COMMITTEE

Walter Stevenson III, Quincy, *Chairman*1980
E. C. Bone, Jacksonville1979
Robert England, Carlinville1981
Robert C. Murphy, Quincy1979
B. Frank Norbury, Jacksonville1981
Edward Ragsdale, Alton1980
James Sutherland, Quincy1980

Seventh District

Alfred J. Kiessel, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham,
Fayette, Macon, Marion, Moultrie, Piatt, Shelby

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
C. R. Daisy, Greenville, <i>Chairman</i>	1981
D. M. Rames, Vandalia	1979
Charles Stanley, Decatur	1979

PEER REVIEW COMMITTEE	
Stanley Moore, Vandalia, <i>Chairman</i>	1979
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H. Gale Zacheis, Decatur	1980
Walter P. Plassman, Centralia	1979

Eighth District

James Laidlaw, Champaign, *Trustee*
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land, Douglas, Edgar, Jasper, Lawrence, Richland, Ver-
milion

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
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James H. Pass, Olney	1981
Michael Murray, Olney	1979

PEER REVIEW COMMITTEE	
Michael Murray, Olney, <i>Chairman</i>	1979
E. T. Baumgart, Danville	1980
George T. Michell, Marshall	1981
George Perlstein, Champaign	1979
C. E. Ramsey, Charleston	1979
Gordon Sprague, Paris	1979

Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*
Counties of Alexander, Edwards, Franklin, Gallatin, Ham-
ilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope,
Pulaski, Saline, Union, Wabash, Wayne, White, Wil-
liamson.

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Alex Goldstein, Harrisburg, <i>Chairman</i>	1979
Eli Borkon, Carbondale	1980
Robert Rader, Anna	1980

PEER REVIEW COMMITTEE	
C. J. Jannings, III, Fairfield, <i>Chairman</i>	1979
Philip D. Boren, Carmi	1980
Herbert V. Fine, Cartersville	1981
James Heersma, Mt. Vernon	1979
Harry L. Lewis, Benton	1981
Charles K. Wells, Mt. Vernon	1979

Tenth District

Julian W. Buser, Belleville, *Trustee*
Counties of Monroe, Perry, Randolph, St. Clair, Washing-
ton

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
H. P. Dexheimer, Belleville, <i>Chairman</i>	1979
Roy Kenney, E. St. Louis	1979
Edilberto Maglasang, Columbia	1979
Wm. A. Simmons, Belleville	1979

PEER REVIEW COMMITTEE	
William H. Walton, Belleville, <i>Chairman</i>	1981
Benjamin Arenas, Belleville	1979
Ted Bryan, Belleville	1979
R. W. Jost, Waterloo	1981
R. E. Schettler, Red Bud	1980
Ron Welch, Belleville	1981

Eleventh District

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Kendall, Will

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
James Ryan, Kankakee, <i>Chairman</i>	1981
Lawrence D. Lee, Manhattan	1979
Merle Otto, Frankfurt	1979
William C. Perkins, West Chicago	1979

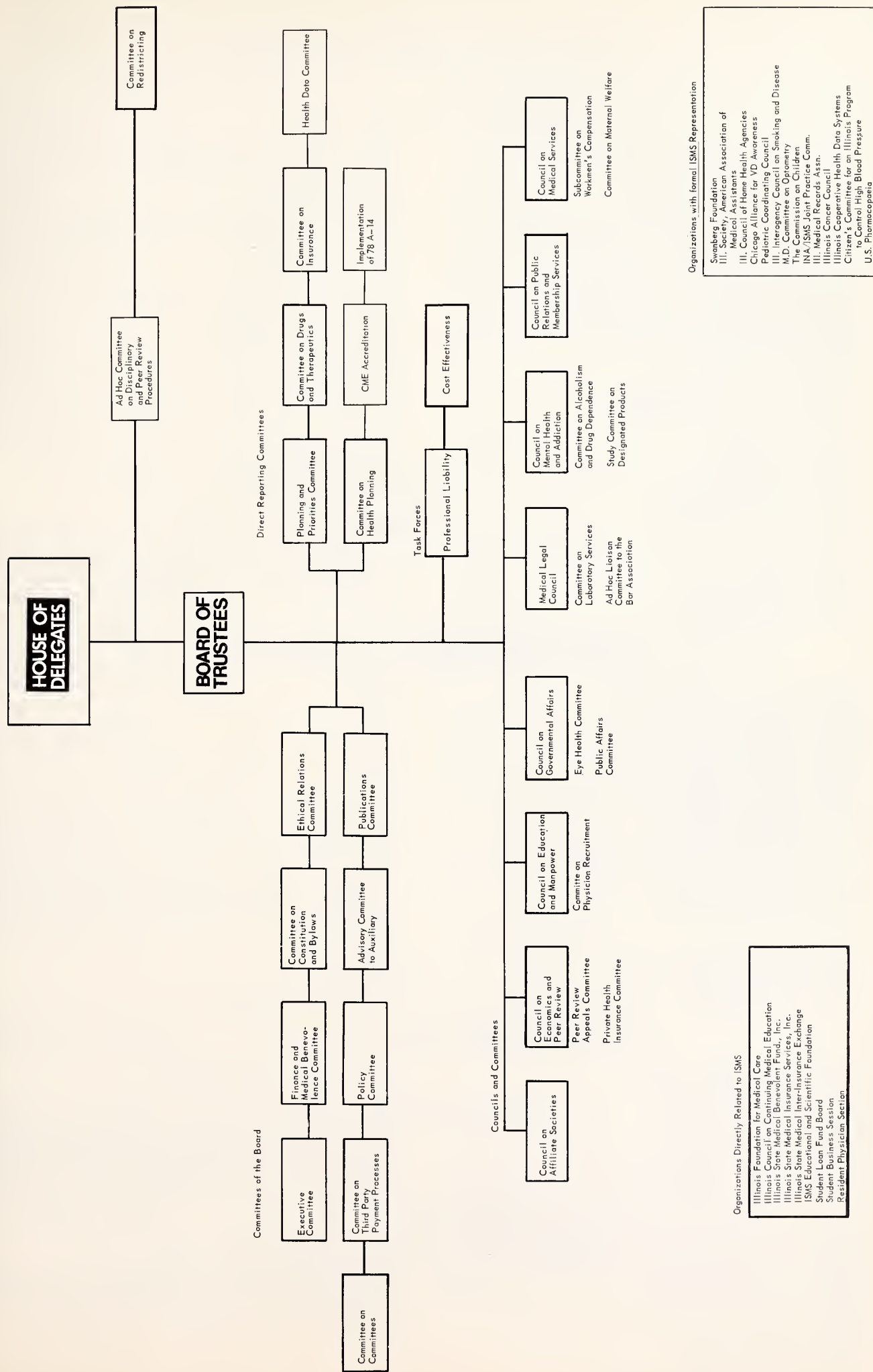
PEER REVIEW COMMITTEE	
James Campbell, Wheaton, <i>Chairman</i>	1981
James E. Dailey, Watseka	1981
James Lambert, Joliet	1979
Guy Pandola, Joliet	1981
A. G. Parkhurst, Kankakee	1980
W. H. Brill, Oswego	1980
Charles G. White, Naperville	1979

Twelfth District

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Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle,
Stephenson, Whiteside, Winnebago

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
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Keith Wrage, Rockford	1980
Frank Luedke, DeKalb	1981
John L. Clark, Freeport	1979

PEER REVIEW COMMITTEE	
Keith Wrage, Rockford, <i>Chairman</i>	1980
Frank Luedke, DeKalb	1981
John L. Clark, Freeport	1979
John H. Steinkamp, Belvidere	1981



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Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Some free standing committees may report directly to the board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, President-Elect, Speaker of the House, and Chairman of the Board are, by virtue of their office, ex-officio members of all groups.

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Ill. Chap., Amer. Coll. of Surgeons
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Ill. Society of Internal Medicine
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Ill. OB-GYN Society
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CONSULTANT:

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STAFF: Division for Specialty Societies

Responsibilities and Purposes:

To improve communication and provide liaison with the specialty societies; provide specialty consultation to other ISMS councils and committees; and to serve as a resource unit to ISMS on advances in the medical specialties.

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Roger N. Pesch, Wheaton
Robert Prentice, Springfield
James J. Rybak, Lincolnshire
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Henrietta Herbolzheimer, Chicago
Joseph Perez, Rockford

RESIDENT

James DeBord, Oak Park

STUDENT

Debbie Frei-Lahr, Chicago

STAFF: Division of Medical Services

Responsibilities and Purposes:

The Council on Economics & Peer Review shall concern itself with: 1) relations with the health insurance industry and prepayment plans; 2) fees and fee adjudication as promulgated by the ISMS; 3) health care cost and utilization; 4) new modes of health care delivery (prepaid programs, surgicenters, etc., peer review and quality of care).

Committees:

Peer Review Appeals
Private Health Insurance

PEER REVIEW APPEALS COMMITTEE

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Robert Prentice, Springfield
John S. Schweppe, Chicago
Frank C. Sedlak, Riverside
Ronald G. Welch, Belleville
Debbie Frei-Lahr, Chicago
STAFF: Division of Medical Services

Responsibilities and Purposes:

The Peer Review Appeals Committee serves as the appellate body for peer review in the state. It considers cases being appealed from local or district Peer Review committees involving quality and cost of medical care. The committee also serves as liaison to local peer review committees.

PRIVATE HEALTH INSURANCE COMMITTEE

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James J. Rybak, Lincolnshire
Alex Spadoni, Joliet
Fred A. Tworoger, Chicago
James DeBord, Oak Park
STAFF: Division of Medical Services

Responsibilities and Purposes:

To conduct ongoing relationships with the private health insurance industry and to deal with issues involving medical policies, reimbursement and complaints.

COUNCIL ON EDUCATION AND MANPOWER

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Murray Brown, Chicago
Milda Budrys, Chicago
Allison Burdick, Jr., Chicago
John Devitt, Springfield
William M. Lees, Hines
Eugene T. Leonard, Rockford
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STUDENT

John P. Johnson (Loyola), Forest Park

CONSULTANTS

Lawrence Hirsch, Chicago
Fred Z. White, Chillicothe

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for paramedical personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

Committee:

Physician Recruitment

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David Clark, Aurora
Robert England, Carlinville
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STUDENT REPRESENTATIVE

Michael I. Kulick, Chicago

CONSULTANTS

Robert T. Fox, Glenview
James Laidlaw, Champaign

STAFF: Governmental Affairs Division

Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Co-operate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Ad Hoc Eye Health
Public Affairs

AD HOC EYE HEALTH COMMITTEE

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Charles Mullenix, Glenview
Burton Russman, Chicago

Frank Snell, Decatur
Robert W. Webb, East Alton

PUBLIC AFFAIRS COMMITTEE

STAFF: Division of Field Services

Responsibilities and Purposes:

The Public Affairs Committee is responsible for educating physicians about the political process and encouraging political involvement. The Committee also provides educational material on issues of interest to physicians and promotes physician involvement in public affairs activity.

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James H. Andersen, Oak Brook
Theodore Grevas, Rock Island
Michael P. Phillips, Chicago
Edward Ragsdale, Godfrey
Albert W. Ray, Jr., Joliet
Ronald E. Sumner, Peoria

AUXILIARY REPRESENTATIVE

Mrs. David Clark, Aurora

MEDICAL LEGAL COUNCIL

Eugene Vickery, Lena, *Chairman*
Donald Aaronson, Chicago
Nelson Borelli, Wilmette
Leonard Klawns, Joliet
Guy Matthew, Glen Ellyn
Morgan Meyer, Lombard
Michael Murphy, Belleville
Lawrence K. Richards, Urbana
Marshall Segal, Chicago
Sam Sugar, Evanston
J. Robert Thompson, Chicago (*Lab. Services*)
Charles Wells, Mt. Vernon

CONSULTANT

Alfred Kiessel, Decatur
STUDENT REPRESENTATIVE
Joseph Fallon, Oak Park

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

The Medical Legal Council shall cooperate with all

organizations interested in medico-legal problems in order to educate members of the profession in medico-legal affairs.

This council shall maintain liaison with the Illinois Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

The council shall study recommendations for methods of elevating and maintaining the standards of medical laboratories in Illinois. In addition, the council shall be concerned with standards of practice, licensure and quackery.

Committees:

Impartial Medical Testimony
Laboratory Services

COMMITTEE ON LABORATORY SERVICES

J. Robert Thompson, Oak Park, *Chairman*
Robert Carrara, Geneva
Joseph O. Dean, Peoria
Newell Braatelein, Moline

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

The committee shall monitor methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.

COUNCIL ON MENTAL HEALTH AND ADDICTION

Arthur R. Traugott, Urbana, *Chairman*
Douglas R. Bey, Normal
Anthony Busch, Belleville
Warren R. Dammers, Harrisburg
Marvin Dehaan, Wayne
Thomas E. Kirts, DeKalb
Geoffrey L. Levy, Arlington Heights
Edward Senay, Chicago (*IPS Liaison*)
Ronald Shlensky, Chicago
Patrick Staunton, Oak Park
James West, Evergreen Park
(*Comm. on Alcoholism & Drug Dependence*)
Arthur Woloshin, Highland Park

CONSULTANTS

George T. Wilkins, Granite City
Cyril C. Wiggishoff, Chicago

RESIDENT REPRESENTATIVE

Jesse Viner, Chicago

STUDENT REPRESENTATIVE

Brad Epstein, Chicago

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

This council shall serve as a source of information on mental health matters for ISMS, evaluate information and make recommendations to the Board of Trustees on positions ISMS should take on issues in this area, and cooperate with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse.

The council shall be on the alert for misleading or fallacious programs and information and recommend appropriate action. It shall also be concerned with reviewing legislation and regulations related to the field of mental health, alcoholism, drug abuse, and hazardous substances.

Committee:

Alcoholism and Drug Dependence

COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

James West, Evergreen Park, *Chairman*
Lee Gladstone, Chicago
Kermit Mehlinger, Chicago
Reinhold Schuller, Bourbonnais
Edward Senay, Chicago
George Stanton, Chicago
W. David Steed, Oak Park
David Stinson, Rockford

CONSULTANTS

Linda Hargnett, DDC, Chicago
Msgr. Ignatius McDermott, Chicago Catholic Charities
J. Roalda Alderman, Div. of Alcoholism, Chicago
Mrs. Harold Keegan, ISMS Auxiliary, Kankakee

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

The Committee shall work closely with public and private agencies on projects aimed at eliminating the mis-

use of alcohol and drugs. The committee's functions include: (1) study, research and disseminate educational information on drugs and alcohol to members of the medical profession; (2) cooperate in the dissemination of information on the causes, prevention, diagnosis and treatment of alcoholism and drug dependence to the medical profession and to the public; (3) recommend acceptable measures for control of distribution and disposal of drugs and hazardous substances, exclusive of radiation products, and (4) cooperate with official and non-official agencies in all matters pertaining to this subject.

In April, 1977, ISMS established the Panel for the Impaired Physician. The Panel, which reports to the Committee on Alcoholism and Drug Dependence, consists of physicians who treat fellow physicians for problems related to alcohol or drug dependence, as well as impairment due to mental or emotional disturbances. Referrals to the Panel are initiated through the chairman of the Committee on Alcoholism and Drug Dependence.

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Mack W. Hollowell, Charleston, *Chairman*
James R. Adams, Winnetka
Robert Boxer, Skokie
Robert Hamilton, Chicago
Richard A. Perritt, Chicago
David Spindel, Chicago
Peter Vinciguerra, Libertyville

CONSULTANT:

Jere Freidheim, Chicago

RESIDENT:

Ira Isaacson, Chicago

STUDENT MEMBER:

Jerrold B. Leikin, Skokie

AUXILIARY REPRESENTATIVE

Mrs. Harlan Failor, Champaign

STAFF: Division of Public Relations and
Membership Services

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.

COUNCIL ON MEDICAL SERVICES

Glen Tomlinson, Lincoln, *Chairman*
Helen C. Bonbrest, Chicago
Joan Cummings, Hines
William W. Curtis, Springfield
Thomas H. Davison, Chicago
Herbert B. Fine, Carterville
Lee Johnson, Litchfield
A. Everett Joslyn, River Forest
Garland P. Kirkpatrick, Chicago
Max Klinghoffer, Elmhurst
David B. Littman, Highland Park
Shirley A. Roy, Chicago
Edward Ryan, Palos Heights
Joseph D. Winterhalter, Rockford

CONSULTANTS:

Alfred Clementi, Arlington Heights
Kenneth A. Hurst, Naperville
Paul Q. Peterson, M.D., Director, IDPH, Springfield
John J. Ring, Mundelein

AUXILIARY REPRESENTATIVE

Mrs. James Gwaltney, Quincy

STUDENT REPRESENTATIVE

Mark DuPuis, Westchester

STAFF: Division of Medical Services

Responsibilities and Purposes:

The Council initiates and implements programs related to health education, medical facilities and services. It also maintains liaison with other health care organizations involved with vocational rehabilitation, Workmen's Compensation, aging, the poor, rural areas and emergency medical services.

In addition, the Council and its Committee on Maternal Welfare cooperate with the Illinois Department of Public Health in the maintenance, protection and improvement of the health of the people of Illinois.

Committees:

Maternal Welfare
Committee on Workmen's Compensation
Ad Hoc Committee on the Generic Prescribing Law

COMMITTEE ON MATERNAL WELFARE

DISTRICTS MEMBERS AND ALTERNATES

(alternates in italics)

William W. Curtis, Springfield, *Chairman*

1. Hugh C. Falls, Lake Forest

Gan L. Tjiook, Geneva

2. William J. Farley, Peru

Carl P. Mattioda, Streator

3. Alex Kaz, Harvey

Charles F. Kramer, Glenwood

4. Ralph Gibson, Peoria

Raoul E. Reinertsen, Canton

5. William W. Curtis, Springfield

Robert Maletich, Springfield

6. Richard D. Yoder, Alton

Donald E. Hardbeck, Alton

7. Herbert W. Thompson, Decatur

8. J. Roger Powell, Urbana

John C. Mason, Jr., Danville

9. William B. Skaggs, Harrisburg

Urduja Pulido, Murphysboro

10. Arthur A. Smith, O'Fallon

Ferdinand J. Mueller, Belleville

11. John J. McLaughlin, Joliet

Charles P. Westfall, Elmhurst

12. John F. Hubbard, Sterling

Gordon T. Burns, Rockford

CONSULTANTS:

Robert R. Hartman, Jacksonville

John Louis, Lake Forest

Augusta Webster, Chicago

STAFF: Division of Medical Services

COMMITTEE ON WORKMEN'S COMPENSATION

Thomas Davison, Chicago, *Chairman*

Ernest F. Adams, Peoria

Harry C. Coblenz, Chicago

Eugene J. Rogers, Chicago

Vincent Sarley, North Chicago

Joseph Schiff, Chicago

STAFF: Division of Medical Services

Responsibilities and Purposes:

To review how physicians are involved and affected by the Workmen's Compensation system in Illinois.

AD HOC COMMITTEE ON THE GENERIC PRESCRIBING LAW

Vincent A. Costanzo, Chicago, *Chairman*

Raymond Dieter, Glen Ellyn

Robert P. Johnson, Springfield

Michael Murphy, Belleville

Richard H. Suhs, Springfield

STAFF: Division of Medical Services

Responsibilities and Purposes:

This Committee is responsible for monitoring the implementation of the Generic Prescribing Law.

STATE TECHNICAL ADVISORY COMMITTEE ILLINOIS JAIL HEALTH PROGRAM, 1978-1979

Robert J. Kramer, Joliet, *Chairman*

Margaret Connolly, Illinois Nurses Association

Robert Davison, Illinois State Bar Association

Lee Johnson, Litchfield

Courtney Jones, Chicago

Barbara Lewis, Association of Administration of
Ambulatory Services

Cecil Patmon, Illinois Department of Corrections

Mary Lou Pflum, Division of Ambulatory Care, IDPH

Tony Slas, Illinois Pharmaceutical Association

Arthur Tyrrell, Illinois Sheriffs' Association

Joseph D. Winterhalter, Jacksonville

STAFF: Division of Medical Services

Responsibilities and Purposes:

To provide overall direction to the Illinois Jail Health Program and assist jails in adapting their health systems to meet national standards for medical care delivery. The STAC Committee is an independent body which reports to the Council on Medical Services.

Committees of the Board of Trustees

COMMITTEE ON CONSTITUTION AND BYLAWS

James Laidlaw, Champaign, *Chairman*
Robert T. Fox, Glenview
Henrietta Herbolzheimer, Chicago
John J. Ring, Mundelein
Cyril C. Wiggishoff, Chicago

CONSULTANT: Legal Counsel

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Committee on Constitution & Bylaws shall:
1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;
2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and
3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

ETHICAL RELATIONS COMMITTEE

Jere E. Freidheim, Chicago, *Chairman*
Julian W. Buser, Belleville
Morris T. Friedell, Chicago
G. W. Giebelhausen, Peoria
Paul F. Mahon, Springfield
Joseph Perez, Rockford

STAFF: Division of Medical Services

Responsibilities and Purposes:

The responsibilities and purposes of this committee are outlined in CHAPTER XI. DISCIPLINE, Part 2 *Illinois State Medical Society Procedures*.

EXECUTIVE COMMITTEE

Robert R. Hartman, Jacksonville, *Chairman*
David S. Fox, Chicago
P. John Seward, Rockford
Herschel Browns, Chicago
Allan Goslin, Streator
Audley Connor, Chicago
George T. Wilkins, Edwardsville
Robert T. Fox, Glenview
EX-OFFICIO (without vote):
Jack L. Gibbs, Canton
BY INVITATION (without vote):
Cyril C. Wiggishoff, Chicago
STAFF: Division of Administration

Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer and the

trustee-at-large. The immediate past chairman of the Board shall be a member, provided he is still a Trustee. If the immediate past chairman is no longer a Trustee, the chairman of the Policy Committee shall serve on the Executive Committee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Allan L. Goslin, Streator, *Chairman*
Alfred Clementi, Arlington Heights
Audley F. Connor, Sr., Chicago
Warren D. Tuttle, Harrisburg

STAFF: Division of Administration

Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to

the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

THIRD PARTY PAYMENT PROCESSES COMMITTEE

P. John Seward, Rockford, *Chairman*
Raymond DesRosiers, Chicago
Allan L. Goslin, Streator
Richard N. Rovner, Chicago
Joseph Sherrick, Chicago
Fred Z. White, Chillicothe

ILL. CLINIC MGRS. ASSOC. REP.
Mr. Sherwin Sern, McHenry

STAFF: Division of Field Services

Responsibilities and Purposes:

The Third Party Payment Processes Committee is responsible for matters concerning the Illinois Department of Public Aid. The Committee deals with Medicaid reimbursement, administration, and auditing practices. The Committee also oversees the Medicaid Membership Services program.

POLICY COMMITTEE

Lawrence L. Hirsch, Chicago, *Chairman*
Alfred J. Kiessel, Decatur
Joseph C. Sherrick, Chicago

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Policy Committee shall consist of three members

of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

PUBLICATIONS COMMITTEE

Herschel Browns, Chicago, *Chairman*
Alfred Kiessel, Decatur
Robert P. Johnson, Springfield
Kenneth A. Hurst, Naperville
Harold J. Lasky, Chicago

CONSULTANT:

Lawrence L. Hirsch, Chicago

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editorial board in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

IMJ Editorial Board

J. William Roddick, Jr., Springfield, *Chairman*
Eli L. Borkon, Carbondale
Daniel R. Cunningham, Wilmette
Raymond A. Dieter, Jr., Glen Ellyn
James G. Ekeberg, Palatine
Ediz Z. Ezdinli, Kenilworth
Carl Neuhoft, Peoria
Constantine S. Soter, Northbrook
Donald D. VanFossan, Springfield

COMMITTEE ON COMMITTEES

Henrietta Herbolzheimer, Chicago, *Chairman*
Julian Buser, Belleville
Lawrence L. Hirsch, Chicago
Paul F. Mahon, Springfield

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Committee on Committees shall consist of three

members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

ADVISORY COMMITTEE TO ISMS AUXILIARY

George T. Wilkins, Jr., Edwardsville, *Chairman*
David S. Fox, Chicago
Robert R. Hartman, Jacksonville

STAFF: Division of Administration

Responsibilities and Purposes:

The committee shall consist of the immediate past president as chairman, the president, and the chairman of the Board. The committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

COMMITTEE ON HEALTH PLANNING

B. Smith Hopkins, Urbana, *Chairman*
Robert A. Clark, Chicago
Robert D. Dooley, Oak Brook
Alexander Z. Goldstein, Harrisburg
Charles J. Jannings, III, Fairfield
M. Kenneth Kaufmann, Greenville
C. B. Lara, Pittsfield
Anthony Raimondi, Chicago

CONSULTANTS:

Henrietta Herbolzheimer, Chicago
Alfred J. Kiessel, Decatur
Fred Z. White, Chillicothe

STAFF: Division of Field Services

Responsibilities and Purposes:

The Committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local areawide health planning agencies.

COMMITTEE ON DRUGS AND THERAPEUTICS

Vincent A. Costanzo, Jr., Chicago, *Chairman*
Norman J. Ehrlich, Chicago
Arthur R. Marks, Fairfield
Richard H. Suhs, Springfield

CONSULTANTS:

Louis Gdalman, R.Ph., Oak Brook
Kerrison Juniper, Jr., Springfield

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

COMMITTEE ON INSURANCE

William A. Henry, Springfield, *Chairman*
Phillip Boren, Carmi
Charles F. Eddingfield, Carthage
B. Franklin Lounsbury, Chicago
Franklin Yanez-Seijo, Chicago

CONSULTANT:

Alfred D. Clementi, Arlington Heights

STAFF: Division of Medical Services

Responsibilities and Purposes:

The Committee on Insurance will review society-sponsored insurance programs, which are currently the Tax Qualified Retirement Program (Keogh Plan), Retirement Investment Program, Group Disability Program, Business Overhead Expense Insurance, Group Major Medical Program, Hospital Benefit Program, and Group Life Insurance. The committee will study these plans, make suggestions for changes, additions and cancellation of policies, and investigate other insurance programs that may benefit society members.

PLANNING AND PRIORITIES COMMITTEE

P. John Seward, Rockford, *Chairman*
Phillip Boren, Carmi
Herschel L. Browns, Chicago
Alfred Clementi, Arlington Heights
Howard Fishman, Hines
David S. Fox, Chicago
Jack L. Gibbs, Canton
Robert R. Hartman, Jacksonville
Lawrence L. Hirsch, Chicago
Eugene P. Johnson, Casey
Robert P. Johnson, Springfield
William M. Lees, Lincolnwood
Joseph B. Perez, Rockford
Albert W. Ray, Jr., Joliet
John J. Ring, Mundelein

Warren D. Tuttle, Harrisburg
Fred Z. White, Chillicothe
Cyril C. Wiggishoff, Chicago
George T. Wilkins, Edwardsville

STAFF: Division of Administration

Responsibilities and Purposes:

The President-Elect shall serve as the Chairman of the Committee on Planning and Priorities. This Committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President.

TASK FORCE ON PROFESSIONAL LIABILITY

Fredric D. Lake, Evanston, <i>Chairman</i> Illinois State Medical Society	David S. Fox, Chicago Ill. State Medical Society	Tassos Nassos, Chicago Ill. State Medical Society
George Andrews, Ottawa Ill. Assoc. Osteopathic Physicians	Morris T. Friedell, Chicago Ill. State Medical Society	Robert O'Leary, Oak Brook Illinois Hospital Association
Thomas Baffes, Park Ridge Chgo. Surgical Society	Herb Gardner, Oak Brook Ill. Hospital Assoc.	Clyde Phillips, Chicago Cook County Phys. Assoc.
Marshall L. Blankenship, Homewood Ill. Dermatological Society	John P. Harrod, Jr., Chicago Amer. Coll. OB-GYN, Ill. Sec.	Mark M. Pomaranc, Chicago Ill. Chap., Amer. Coll. of Phys.
Edmund C. Bolton, Chicago Ill. Chap. Am. Coll. of Emergency Phys.	Welland A. Hause, Decatur Ill. Soc. of Pathologists	Karl Richardson, Chicago Chicago Dental Society
Phillip D. Boren, Carmi Illinois State Medical Society	Henri Havdala, Chicago Ill. Soc. of Anesthesiologists	David Rothstein, Chicago Ill. Psychiatric Society
Joseph Caminiti, Oak Brook Ill. Hosp. Assoc.	Robert P. Johnson, Springfield Ill. State Medical Society	Carlo Scuderi, Chicago Ill. Orthopaedic Society
Clinton L. Compere, Chicago Ill. Orthopaedic Society	Alfred J. Kiessel, Decatur Ill. State Medical Society	Irwin A. Smith, Northbrook Ill. Academy of Family Phys.
George G. Curl, Oak Park Chgo. Urological Society	Harold Kirk, Oak Park Ill. Assoc. of Ophthalmology	Thomas Starshak, Aurora Ill. State Dental Society
David L. Doud, Normal Amer. College of Surgeons	Robert E. Knight, Normal Ill. Soc. of Ophth. & Otolaryngology	Thomas Szwed, Chicago Ill. Assoc. Osteo. Phys. & Surgs.
Charles F. Downing, Decatur Ill. Chap., Amer. College of Phys.	Harold Lasky, Chicago Chicago Radiological Society	Walter W. Whisler, Chicago Ill. Neurosurgical Society
Ill. Society of Internal Med.	Robert Lindley, Chicago Chicago Medical Society	Richard S. Wilbur, Lake Forest Ill. State Medical Society
Thomas P. Driscoll, Chicago Ill. Chap., Amer. Academy of Pediatric	James H. Mason, Evanston Ill. Surgical Society	Don Wood, Chicago Chicago Hospital Council
Deane M. Farley, Riverside Ill. OB-GYN Society	Guy Matthew, Chicago Ill. Radiological Society	
	Peter McKinney, Chicago Chicago Society of Plastic Surgery	CONSULTANTS: Joel Edelman, Esq.

TASK FORCE ON COST EFFECTIVENESS

J. M. Ingalls, M.D., Paris, <i>Chairman</i> (ISMS)	Mr. Gerald Mungerson, Chicago (Ill. Hosp. Assoc.)
Mr. Stephen Dorn, Chicago (Chgo. Hosp. Coun.)	Mr. Robert O'Leary, Oak Brook (Ill. Hosp. Assoc.)
Mr. Martin Drebin, Evanston (Ill. Hosp. Assoc.)	Clifton L. Reeder, M.D., Park Ridge (Chgo. Med. Soc.)
David S. Fox, M.D., Chicago (ISMS)	Mr. Philip J. Sayles, Woodstock (Ill. Clinic Mgrs. Assoc.)
Robert T. Fox, M.D., Glenview (ISMS)	Mr. Frank Schwermin, Highland Park, (Chgo. Hosp. Coun.)
Morris T. Friedell, M.D., Chicago (Chgo. Med. Soc.)	Mr. Steve L. Seiler, Lake Forest (Ill. Hosp. Assoc.)
Mr. Peter Goschy, Oak Brook (Ill. Hosp. Assoc.)	P. John Seward, M.D., Rockford (ISMS)
Mr. Charles Goulet, Chicago (BC-BS)	Richard C. Shaw, M.D., Chicago (BC-BS)
Robert R. Hartman, M.D., Jacksonville (ISMS)	Mr. James R. Slawny, Chicago (ISMS)
Mr. F. Regis Kenna, Addison (Ill. Hosp. Assoc.)	Mr. Roger N. White, Chicago (ISMS)
Mr. Robert Lindley, Chicago (Chgo. Med. Soc.)	
Mr. James Mortimer, Chicago (Loop Bank Task Force on Health)	

AD HOC HOUSE COMMITTEE TO STUDY REVISIONS OF DISCIPLINARY AND PEER REVIEW PROCEDURES

A. Everett Joslyn, River Forest, *Chairman*
James DeBord, Oak Park
Jere E. Freidheim, Chicago
Robert R. Hartman, Jacksonville
Lawrence L. Hirsch, Chicago
A. Beaumont Johnson, Elgin
Fredric D. Lake, Evanston
Michael E. Murray, Olney
Joseph R. O'Donnell, Glen Ellyn

CONSULTANT:
Fred Z. White, Chillicothe

STAFF: Division of Medical Services

Responsibilities and Purposes:

This committee was formed at the 1977 annual House of Delegates meeting to study and recommend revisions in the Society's disciplinary and peer review procedures. It reports directly to the House of Delegates.

Other Appointments and Representatives

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Jack Gibbs, Canton, *Chairman*

Albert G. Bledig, Eldorado

Thomas Schrepfer, Havana

STAFF: Division of Education, Manpower and
Convention Services

Purpose:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

INA-ISMS JOINT PRACTICE COMMITTEE

James E. Coeur, Carthage

Robert M. Reardon, Bloomington

Fred Z. White, Chillicothe

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The purposes and objectives of the committee shall be to: (1) improve communication between medicine and

nursing to enhance joint planning and action; (2) examine roles and functions in medical and nursing practice with definition of new and altered patterns; (3) propose changes in educational patterns and relationships that would enhance the new role functioning of nurses and physicians; (4) define, identify and examine health care needs; (5) address the traditional problems which affect nurse-physician relationships in order to establish enhanced role functioning, and (6) identify and address the ensuing problems related to basic role reorganization.

ILLINOIS COOPERATIVE HEALTH DATA SYSTEMS

Audley F. Connor, Chicago

Joel Edelman, *Legal Counsel*, ISMS

Alexander Goldstein, Harrisburg

Allan L. Goslin, Streator

Donald H. Hanscom, Hinsdale

Henrietta Herbolzheimer, Chicago

James A. McDonald, Geneva

Joseph R. O'Donnell, Glen Ellyn

Clifton L. Reeder, Park Ridge

Roger N. White, *Executive Administrator*, ISMS

Ben T. Williams, Urbana

ISMS REPRESENTATIVES TO OTHER GROUPS

SWANBERG FOUNDATION, QUINCY

Robert R. Hartman, Jacksonville

LIAISON TO ILL. SOC. OF THE AMER. ASSOC.
OF MED. ASSTS.

J. M. Ingalls, M.D., Paris

ILLINOIS COUNCIL OF HOME HEALTH AGENCIES

Shirley A. Roy, Chicago

CHICAGO ALLIANCE FOR VD AWARENESS

Mark DuPuis, Westchester

PEDIATRIC COORDINATING COUNCIL

Daniel Pachman, Chicago

ILL. INTERAGENCY COUN. ON SMOKING AND DISEASE

Charles L. Swarts, Oak Park

ILLINOIS MEDICAL RECORDS ASSOC.

David T. Petty, Chicago

MD COMMITTEE ON OPTOMETRY

Samuel Schall, Chicago

STATEWIDE COOPERATING ORGANIZATIONS OF THE
COMMISSION ON CHILDREN

Daniel Pachman, Chicago

ILLINOIS CANCER COUNCIL

William M. Lees, Lincolnwood

CITIZENS COMMITTEE FOR AN ILLINOIS PROGRAM TO
CONTROL HIGH BLOOD PRESSURE

David Littman, Glencoe

U.S. PHARMACOPAEA

Joseph Skom, Chicago

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference section. Members who wish to notify Chairman of the Board of their availability can clip and submit the coupon below.

NAME: _____

ADDRESS: _____ CITY: _____ ZIP: _____

TELEPHONE: () _____

COUNTY MEDICAL SOCIETY: _____

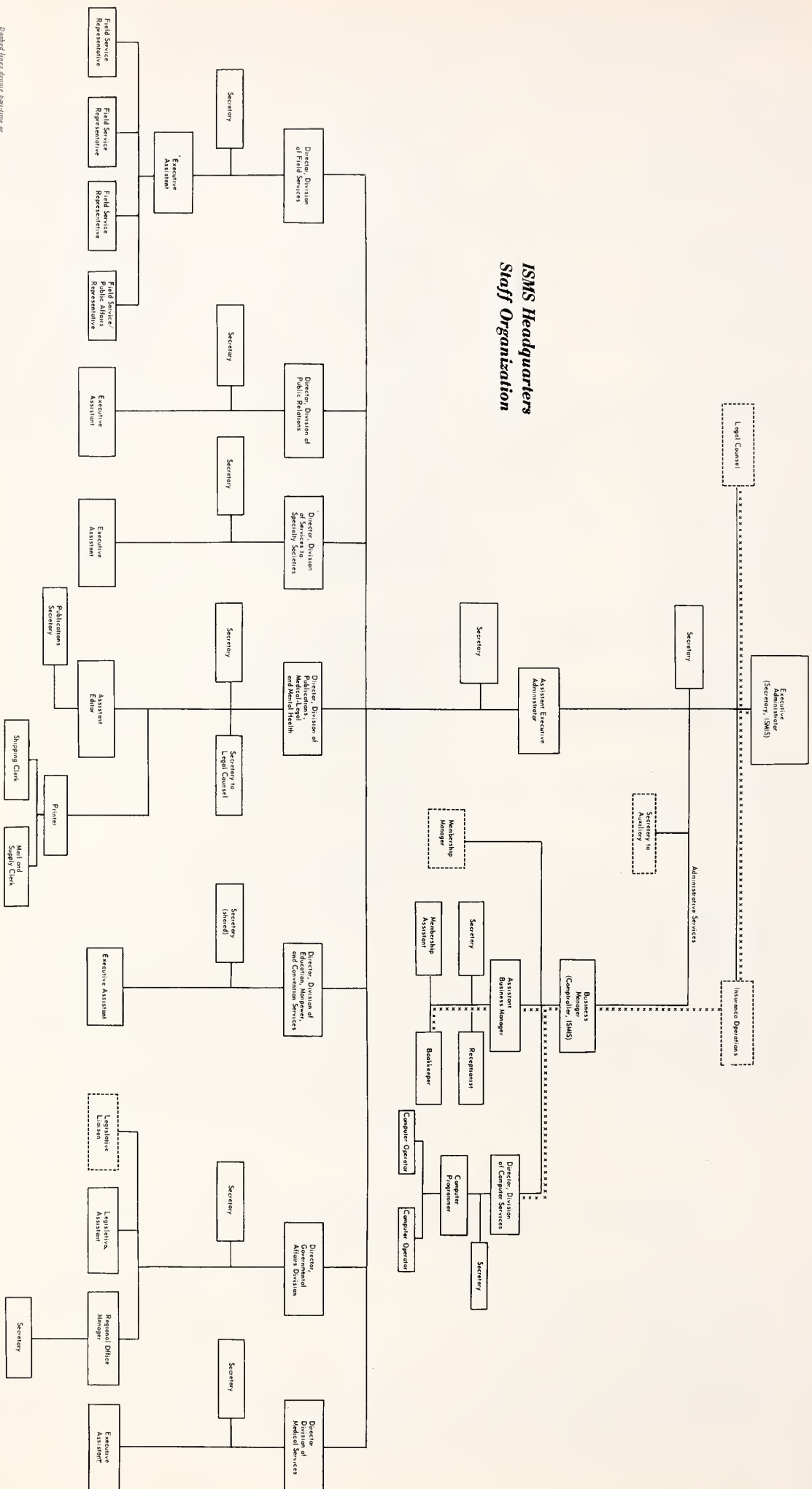
MEDICAL SPECIALTY AND TYPE OF PRACTICE _____

COMMITTEE IN WHICH INTERESTED: _____

EXPERTISE FOR THIS COMMITTEE: _____

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society
55 E. Monroe, Suite 3510, Chicago, IL 60603

ISMS Headquarters Staff Organization



Dashed lines denote part-time or contractual personnel

ISMS SERVICES

Pursuit of Obligations

CONSTITUTIONAL PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 55 East Monroe St., Suite 3510, Chicago, and an office in Springfield at 701 S. Second St. Services of the Society, under the general supervision of Roger N. White, Executive Adminis-

trator, are conducted by the following divisions:

Administration; Public Relations and Membership Services; Governmental Affairs; Publications, Medical Legal and Mental Health; Education, Manpower, and Convention Services; Medical Services, Field Services, Computer Services and Services to Specialty Societies.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are general descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

Specific areas of responsibility and staff assignments will be identified to any member upon request.

DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the Speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action. The Administrator channels all legal inquiries and works with the

General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

The headquarters office has been organized by divisions to provide the membership of the Society with the best professional staff services available.

The Assistant Executive Administrator serves within this Division as a coordinator for programs of the state society. Further coordination between programs of the State Society and the County Medical Societies is achieved through Field Services Representatives.

The accounting and business service functions of the Society are handled by the Business Manager as a part of this Division. The Division also maintains the membership records and provides a computerized central dues billing and collection center for county medical societies. The Society's accounting and membership records are handled in close coordination with the Secretary-Treasurer under policies laid down by the Finance Committee and the Board of Trustees.

DIVISION OF COMPUTER SERVICES

This Division was established in 1976 as a result of the Board of Trustees authorization to purchase a computer for the purpose of cataloging claim statistics in conjunction with the Hartford Liability Insurance program, sponsored by ISMS. Computer requirements were soon increased when the doctor-owned Insurance Exchange was established that same year. Insurance Services currently uses ISMS hardware and operations for its broad variety of problems.

Computer services are provided internally to ISMS for

its centralized membership dues billing and collection system, financial record keeping and label production for the many Society mailings. A physician data base is currently being assembled as an information source for our councils and committees.

The Computer Service Division is being organized to provide limited time sharing arrangements and services to outside organizations. As we complete internal projects we shall seek further users in our effort to continue a cost effective system.

DIVISION OF EDUCATION, MANPOWER AND CONVENTION SERVICES

The Division of Education and Manpower was established in response to the growing demands created by the rapid changes in the education and utilization of physicians and other health care personnel. A primary responsibility of the Division is to maintain information on the changes in medical education. The Division works in concert with the AMA in keeping abreast of changes in medical school curricula, and in postgraduate medical education.

In addition, the Division attempts to maintain current information on the training and use of such ancillary personnel as nurse practitioners and physician's assistants. New and innovative use of personnel are studied and

recommendations made to the ISMS Board of Trustees as to their appropriateness and legality. All information maintained by the Division is, of course, available to all ISMS members.

The Division maintains liaison with the Department of Registration and Education to ensure that any licensure problems may be handled expeditiously. It is also responsible for coordinating meetings and conventions for all divisions, as well as the services and arrangements incident to the annual and interim sessions and provides staff services and the Resident Physicians Section, Student Business Session, and the American Association of Medical Assistants, Illinois Society.

DIVISION OF FIELD SERVICES

The primary responsibility of Field Services is to provide liaison, service and education to the Society's membership through Field Service Representatives. Each Field Representative has the responsibility for liaison with component societies, allied professions and government agencies, to insure State Society representation and to provide a means for communication; service to the trustees, officers, executives, general membership and county medical societies; to provide a constant update on ISMS information, programs and resources; and education to the general membership through the distribution of a wide variety of issues affecting the practice of medicine.

Specific areas of activity include health planning, President's Tour, Trustee District meetings, the legislative Key-Man program, public affairs activity, Medicaid and Medi-

care membership services, audit assistance, and CHAMPUS professional relations.

Additional division activities include staffing the Third Party Payment Processes Committee, which deals with Medicaid matters; the Health Planning Committee, which closely follows the activities of the State Planning Agency, Statewide Health Coordinating Council, Illinois Health Facilities Planning Board and local Health Systems Agencies; and the Public Affairs Committee, which conducts activities designed to educate physicians about the political process.

Staff of the Division attend meetings of governmental and professional organizations involved in the above described areas and participate in hearings and programs used to develop policy and programs regarding these issues.

GOVERNMENTAL AFFAIRS DIVISION

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically-related pieces of legislation.

The ISMS Governmental Affairs Council acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legislature is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Other Activities

The division also staffs the Ad Hoc Eye Health Committee.

DIVISION OF MEDICAL SERVICES

To respond to the social and economic issues facing physicians, the Division of Medical Services has the responsibility for conducting ongoing liaison activities with various public, governmental, professional and private organizations. Through the Council on Economics and Peer Review, and the Council on Medical Services, the Division reviews current subjects affecting the physician and his relationships with patients, medical facilities, public health programs, and health insurance carriers. The products of council meetings may take the form of educational seminars, informational materials, legislation, or position statements.

The Division is also responsible for staffing the ISMS Committee on Insurance—which monitors the Society's sponsored insurance programs for the membership—and the Ethical Relations Committee, which conducts disciplinary procedures in accordance with Chapter XI of the ISMS Constitution.

Council on Medical Services

This council studies issues and recommends actions relating to maternal welfare, workmen's compensation, public health, nutrition and school health programs, medical facilities, health care delivery systems and the special needs of the poor, the elderly, prisoners and those in our rural communities. Representatives from the Illinois Department of Public Health serve as consultants to the council providing the necessary expertise to participate in developing programs and policies for the public sector.

Council on Economics and Peer Review

Principal duties of the Council on Economics and Peer Review include keeping abreast of problems which arise out of the physician's relationships with patients and third-party payors and monitoring the peer review process in our state. These activities are the responsibility of the Council's committees on Private Health Insurance and Peer Review Appeals. Serving as consultants to the Council are representatives from the Health Insurance Association of America (HIAA) and the Illinois Blue Cross/Blue Shield Association.

Committee on Insurance

ISMS offers seven insurance plans as benefits to the membership. Life, Hospital Benefit, Major Medical, Excess Major Medical, Disability, Business Overhead and Worker's Compensation programs are underwritten and administered through outside organizations. These are monitored, and periodically modified, by the Committee to reflect the changing needs of the membership.

Ethical Relations Committee

This committee, composed of ISMS Trustees, is responsible for implementing Chapter XI, the Disciplinary section of the ISMS Constitution. It only meets when a case is appealed to the State Society following a hearing at the local or District level.

As new medical delivery systems are developed, the Division will expand its activities to prepare physicians for the inevitable changes in their practice environment.

DIVISION OF PUBLICATIONS, MEDICAL-LEGAL, AND MENTAL HEALTH

The Division of Publications, Medical-Legal and Mental Health is charged with staff responsibility for activities associated with the Council on Mental Health and Addiction, Medical Legal Council, and the Publications Committee. Under the councils are several committees and subcommittees. In addition, liaison is maintained with many public and voluntary organizations, on a formal basis, in order to keep abreast of current developments and to ensure representation of the Illinois State Medical Society. Staff functions include various activities in professional liability, as well as work on specific problem areas allied to medical-legal concerns.

Publications

Total production of all printed materials and publications, as well as their distribution, is this division's responsibility, except for distribution of items to selected specific groups. Printing and duplicating services are furnished either through an in-plant shop or outside services through competitive bidding.

In addition, mail room services are provided by this division. An addressograph and graphotype are utilized as well as a small wing mailer, folder and stuffer, and plate burning cabinet.

Principal among the publications of the society is the official organ, the *Illinois Medical Journal*. The *Journal* is mailed monthly to all members, as well as other selected individuals, who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state, as such pertain to the practice of medicine.

"Action Report" is an in-house publication totally produced in the ISMS print shop. Special publications, brochures, flyers, pamphlets, letters and cards as required by the several ISMS and ISMIS divisions to carry forth their mission, are produced.

Needs of groups affiliated with or ancillary to ISMS, insofar as reproduction or distribution services are concerned, are also handled through the division office.

DIVISION OF PUBLIC RELATIONS AND MEMBERSHIP SERVICES

The Division of Public Relations functions both as an outlet to the news media and as a source of information for the membership.

Staff members prepare speeches, slide presentations, pamphlets and other materials on a wide range of topics to support activities of officers, councils and committees. In addition, the Division arranges press conferences and prepares news releases to publicize ISMS actions and views on major issues. Also, the Division serves as liaison to the news media, responding to almost daily requests for background information or summaries of society activities.

Beyond these traditional public relations duties, the Division conducts a number of special, highly successful projects. Among them are:

President's Tour . . . takes the ISMS President to each Trustee District and provides an opportunity for members to discuss with the president matters affecting medicine and the society. An integral part of the "tour" is

press conferences and media interviews as well as civic club speaking engagements arranged by the division.

Action Report . . . is a periodic newsletter which reports on ISMS activities and major events affecting medicine.

AID (Athletics . . . Injury and Disease) . . . assists coaches and trainers in prevention, recognition and initial treatment of injuries and illnesses. This quarterly sports-medicine newsletter is distributed to approximately 2,000 junior and senior high school coaches and trainers in Illinois.

Radio-TV Speaker's Bureau . . . provides physicians to discuss general medical topics on regularly-scheduled programs. In addition, the bureau provides physician speakers for civic, fraternal, church and community groups.

Public Service Radio Announcements . . . providing general health information are distributed to approximately 150 Illinois radio stations.

DIVISION FOR SPECIALTY SOCIETIES

The Division for Specialty Societies—established in March, 1978 to provide closer liaison with medical specialty organizations—provides staff services to four Illinois specialty societies with a combined physician membership of 2,800. Services also are provided to the Illinois Medical Group Management Assn., a group of 150 clinic administrators.

The Division is responsible for handling daily operations of the component groups. Its primary responsibilities may be divided into the following areas: (1) routine office management, correspondence and inquiries; (2) meeting arrangements; (3) membership promotion and record keeping; and (4) dues collection and accounting records. Division staff also handle inquiries from the general public regarding activities of the five organizations. The Division also is responsible for preparing membership newsletters for each group. Staff services are pro-

vided to the participating organizations on a cost basis.

An important function of the Division is to maintain liaison between ISMS and specialty society officers by forwarding copies of ISMS Board of Trustees abstracts, press releases and other materials to the specialty organizations. The arrangement also permits a close liaison with other ISMS divisions whose activities affect specialty society interests, such as the Division of Publications, Medical-Legal and Mental Health and the Governmental Affairs Division.

The Division also staffs the Council on Affiliate Societies. Composed of representatives from 21 Illinois specialty societies, the Council is responsible for improving communication and providing liaison with the specialty societies; providing specialty consultation to other ISMS councils and committees; and serving as a resource unit to ISMS on advances in the medical specialties.

SPECIAL PUBLICATIONS

Action Report

"Action Report" is a periodic newsletter published by the Illinois State Medical Society. It is distributed to members upon request. Purpose of the report is to alert physicians to important events or activities affecting the practice of medicine.

A short deadline ensures that important news is disseminated to the physicians as quickly as possible so that appropriate responses may be made.

On the Legislative Scene

Emanating from the Springfield Regional Office is a weekly newsletter, "On the Legislative Scene," published during the weeks the General Assembly is in session.

This is produced by the Governmental Affairs Division and distributed upon request. It includes up-to-the-minute status reports on pending legislation of vital concern to medicine in Illinois. This well-received periodical has permitted immediate response by ISMS representatives in Springfield to specific bills and has alerted physicians to the need for involvement in public affairs.

SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances by conducting postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a \$50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharpe & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

In February, 1978, a special adjunct to the Scientific Speakers Bureau was formed through a grant

from the Illinois Department of Mental Health and Developmental Disabilities, Division of Alcoholism. That grant facilitates presentations by a special roster of speakers in alcoholism education.

The following procedures govern use of the Bureau:

- 1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

- 2) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

- 3) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

- 4) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

PHYSICIAN RECRUITMENT & STUDENT LOAN FUND PROGRAMS

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activi-

ties. First is its own Physician Recruitment Program & Doctor's Job Fair. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

PHYSICIAN RECRUITMENT PROGRAM

The Physician Recruitment Program is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a physician.

More than 600 medical doctors have been placed through this program since its inception shortly after World War II.

The Physician Recruitment Program maintains an up-to-date listing of some 125 "open" areas needing physicians.

This service accepts requests from both physicians and communities for placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association and the Illinois Agricultural Association. Frequently, responsible

citizens or overburdened physicians in a community will contact the service.

The Physician Recruitment Program sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics.

The Physician Recruitment Program offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society.

Another important function of the Physician Recruitment Program is to assist small communities in developing programs to attract physicians such as the Doctor's Job Fair.

ILLINOIS MEDICAL STUDENT LOAN FUND PROGRAM

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician, but lack sufficient financial resources or a recommendation for medical school.

Loans to students in need are provided by a joint contribution from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans up to \$750 per semester for four years. The total amount of loan funds available varies from year to year, depending on repayments into the revolving fund. The amount of each individual loan is determined by the student's current

financial need. A low interest rate is charged from the time the loan is received. The borrower also must insure himself for the entire amount of the loan and pay premiums on the policy. Repayment begins January 1 of the fourth year following medical school graduation.

The program also offers assistance to those who may not have financial difficulties, but are denied matriculation into medical school because their college grades or Medical College Admission Test (MCAT) scores are marginal. The board representing the sponsoring organizations of the program can recommend candidates annually to the Uni-

versity of Illinois College of Medicine. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must agree to practice medicine in an Illinois town serving a rural population. Minimum practice time is:

(1) Freshman student receiving recommendation—five years of practice.

(2) Freshman student receiving financial assistance for four years—four years of practice.

(3) Upper classman already in medical school—one year of practice for each year that financial aid is taken (one year minimum).

The applicant may select a practice location of his own choice, provided it is in a community that has a demonstrated physician shortage. The choice is subject to approval by the program's board. The purpose of this agreement is to provide physicians for the rural com-

munities of Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a premedical student of at least three years college standing; applicants must also complete the required American Medical College Admission Service forms. This AMCAS application must be on record with the University of Illinois Medical School by November 1. Illinois residency is required.

The board of the Medical Student Loan Fund Program conducts an annual interview meeting for those students who wish to enter medical school the following September. Students qualifying for the interview are notified and invited in mid-November. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, Manager, Medical Student Loan Fund Board, 1701 Towanda Ave., P.O. Box 2901, Bloomington, IL 61701.

IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is divergence of medical opinion in litigation before the court. An IMT examination provides the court with objective, impartial medical data and opinion.

The Illinois State Medical Society played a significant role in the creation and development of the IMT program.

The panel of impartial medical examiners is comprised of physicians who are grouped into medical specialties. Composition of the panel is reviewed periodically to maintain the highest standards for the courts of Illinois.

In 1976 the functions of IMT were expanded to provide service to the Supreme Court Attorney Registration and Discipline Commission.

SPONSORED COMMERCIAL INSURANCE PROGRAMS

Hospital Benefit Plan

The Hospital Benefit Plan, approved by the Board of Trustees March 14, 1971, is available exclusively as a benefit to ISMS members. The society will incur no expense as a result of sponsoring this voluntary program.

The Hospital Benefit Program consists of three plans. Plan A provides \$25 per day, Plan B provides \$50 per day and Plan C provides \$100 per day for each day you are confined in a hospital as an in-patient because of an accident or sickness for as long as one year. Benefits are provided from the first day of in-patient hospital confinement in any general hospital which has available 24-hour nursing services and has facilities for major surgery.

All active members of the society, their employees and their families are eligible for participation during enrollment periods conducted by the Administrator, Robinson Administrative Services, Inc., 209 S. LaSalle St., Chicago 60604.

The daily benefits are automatically doubled for all participants under age 65 for hospital confinement due to cancer or hospital confinement in an intensive care unit.

The plan pays regardless of any other insurance policies members have, and in addition to Medicare and Social Security benefits. Benefits are paid directly to the participant and not to a doctor or hospital,

unless assigned. Benefits are not taxable and therefore need not be included in one's tax return.

The coverage is limited to sickness which commences or accidents which occur while the insurance is in force. However, conditions pre-existing the effective date of insurance will be covered if the participant has not received treatment or medical advice during any period of 12 consecutive months ending after the effective date of insurance. After two years from the effective date of insurance, coverage is guaranteed regardless of any pre-existing conditions.

The plan includes these exclusions: war or act of war, service in the armed forces of any country or international authority at war, pregnancy (including childbirth or resulting complications), or intentionally self inflicted injuries, suicide or attempted suicide, whether sane or insane.

Enrollment forms and details about the plan can be obtained by calling the Administrators Office, collect, at (312) 726-2575.

Group Disability Program

The Group Disability Program has been available to members since 1947. All eligible members of ISMS may apply if under age 55 and regularly attending all of the usual duties of their profession. The coverage is renewable to age 70 and offers three choices—Lifetime Accident and (1) Sick-

ness payable to age 65, (2) Sickness payable for 7 years, (3) Sickness payable for 1 year.

New members under age 40 joining ISMS may enroll without evidence of insurability for up to \$400.00 per month. Benefits under Plan I, (lifetime accident, 1 year sickness). The plan offers up to \$1732.00 per month benefits to members under 50 and \$1300.00 per month benefits to members under age 55.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

The program is explained in detail in a brochure which is available by writing to the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60077.

Excess Major Medical Plan

This Plan has been available to members since 1975. It is a coverage designed for the truly catastrophic accident or illness condition. The plan provides up to \$500,000 for medical expenses. It is available with a \$15,000, \$20,000 or \$25,000 deductible which supplements any Basic Major Medical Plan. It may be obtained without evidence of insurability. You have 36 months to accumulate the deductible and then the benefits are paid on a 100% basis for up to 10 full years.

For additional information, please contact the Administrator, Parker, Aleshire & Company, 9933 Lawler Avenue, Skokie, Illinois 60077.

Workers' Compensation Insurance

The Dodson Savings Plan has been approved by the Illinois State Medical Society as a proven way to reduce the cost of Workers' Compensation insurance when claim costs are held to a minimum.

Savings for physicians in other areas such as Minnesota have frequently been 40% or more. Returns under this plan depend on the cost of claims from physicians who are insured. Policies are issued by Casualty Reciprocal Exchange, a member of the Dodson Insurance Group, and are standard in all respects. Rates are standard and approved for this class of employment. Savings are best when safety is maintained in all job related activities.

Savings are paid as earned within about 90 days after policy expiration or when payroll audits are completed.

For further details write or call collect to the managers, Dodson Insurance Group, P.O. Box 559, Kansas City, MO 64141. Phone 816-361-3400.

Group Major Medical Expense Plan

The \$25,000 Group Major Medical Expense Plan designed for the Illinois State Medical Society has been in force since 1958. It has a 20% co-insurance feature with a \$500 or \$1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to \$100 a day and in addition up to \$150 a day in an intensive care unit. It will pay \$20 a day in a convalescent home following

release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to \$2,000 for dependents. It will also cover a congenital abnormality from the first day of birth after the effective date of the contract up to \$2,000.

New members joining ISMS will be allowed to enroll without evidence of insurability or health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

Further information may be obtained from the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie, Ill. 60077.

Business Overhead Expense Group Plan

This plan has been available since 1973. Today, more than ever, maintaining a medical office is costly when one considers the increasing cost of rent, employee's salaries, accountant services, utilities, etc. The sole purpose of the Business Overhead Expense Group Plan is to step in and take care of overhead expenses during a period when the physician is totally disabled as a result of an accident or illness. In the event of a serious accident or illness, the physician can keep his office open and retain his personnel with the expenses being taken care of by the Business Overhead Expense Group Plan. This Program is not to be confused with the Group Disability Plan which provides an earned income for physician to meet his personal obligations for the maintenance of his home and family.

Monthly benefits are available up to \$3,500.00 with attractive premiums. Benefits commence on the first day provided total disability lasts one (1) month or longer. It will continue while totally disabled for as long as 24 months for any one accident or period of sickness. The premiums for this particular type of coverage constitute business expenses and are deductible under Internal Revenue Service Ruling (55-264, I.R.B. 1955-19, p. 8).

Further information may be obtained from the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie, Ill. 60077.

Personal Life Insurance Program

A guaranteed renewable term life insurance program, recommended by the Insurance Committee and approved by the Board of Trustees in 1972, is available to ISMS members in amounts ranging from \$10,000 to \$200,000. Features of the program include guaranteed future purchase options, guaranteed conversion privilege up to age 70, optional family insurance benefits, double indemnity and disability waiver premium.

Dividends are applied against premiums and reduce member's cost.

For applications and further details, contact the administrator: A. W. Ormiston & Co., 175 W. Jackson Blvd., Chicago 60604; phone 312-922-3952.

Ancillary Organizations

Illinois State Medical Society Auxiliary

Growth Patterns for 1978-79

It has been said that "two women with a cause and a letterhead can produce stark terror in the hearts of sophisticated corporate heads."

With that thought in mind, one can envision the built-in potential of our state medical auxiliary for achievement. This is yet more valid when the calibre of its members and worth of its goals are taken into account.

Illinois is one of the few states with an increase in auxiliary membership. Our on-going community action projects include CPR training in the schools, Immunization Awareness and Education, Safety for the Elderly and the Vial of Life program. Our cooperative efforts with the Cancer Society and Illinois Heart Association are further evidence of involvement and interest in the quality of life in our state.

It seemed only natural that we choose "Fifty-One to Grow on" as our theme this year. We boast a newly organized county and give a warm welcome to Coles-Cumberland. That is growth, indeed; growth of the very best kind.

Each organized county has now filled the position of president-elect. Each president-elect is eligible to participate in the leadership training sessions given in Chicago every October. It would be difficult to describe the excellence and effectiveness of "Leadership Confluence."

Since the inception of the fall conference concept five years ago, interest has grown to engender the possibility of regional conferences. We have scheduled two this year, in order to test the merit of that idea.

Our September 19 Fall Conference-North gave emphasis to the fact that we are not interested solely in the concerns of children, but also in the family as a whole. Our youth cannot blossom and mature unless nurtured in a healthy, balanced environment, and the core of that environment must be a warm, harmonious home.

The broad range of subjects touched upon at the workshop included parenting—how much substitution can there be without harm? Personal responsibility for health was discussed. Dr. Nelson J. Bradley of the ISMS Panel for the Impaired Physician discussed the successful fam-

ily treatment approach to alcohol and drug-related problems.

The auxiliary presented a new legislative film entitled "A Critical Difference" to those assembled. It was produced by the legislative department of the AMA, and our members were urged to make full use of this effective tool during the coming months. It will be available for all, and is designed for non-medical persons in our communities.

Fall Conference-South is scheduled for Thursday, November 9th, at the Ramada Inn, St. Clair Square in Belleville, Illinois. Cost Containment is on the agenda, along with reports from Leadership Confluence.

At this point, our future lies before us. There are endless opportunities for challenge and growth, as we work to leave the youth and families of Illinois enriched and restored through auxiliary's efforts over the next several months.

Mrs. Earl V. Klaren
President

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 Spouses of Physicians in
 TrainingMrs. Edward Szewczyk, Belleville
 EditorialMrs. Eugene Vickery, Lena
 Co-ChairmanMrs. Morrison Beers, Lake Forest
 Contributing ReportersMrs. Irving Frank, DeKalb
 Mrs. Luben Atzeff, Lake Forest
 Mrs. Harold Keegan, Kankakee
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 Mrs. Willard Scriver, Belleville
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 AwarenessMrs. George Olander, Lake Forest

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 Mrs. Edward Dutka, Aurora
 AMAA North Central Region AMA-ERF
 ChairmanMrs. Edward Szewczyk, Belleville
 ParliamentarianMrs. Francis Graff, Freeport

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 Mrs. Earl V. Klaren, Libertyville
 Governmental Affairs ..Mrs. Byron Weisbaum, Springfield
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 AddictionMrs. Harold Keegan, Kankakee
 Public AffairsMrs. David Clark, Aurora
 Public Relations &
 MembershipMrs. Harlan Failor, Champaign
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DISTRICT COUNCILORS

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| 5. Mrs. Robert Reardon, Bloomington | 11. Mrs. Alex Spadoni, Hinsdale |
| 6. Mrs. Robert Kooiker, Jacksonville | 12. Mrs. John Leonard, Roscoe |
| 7. Mrs. William Simon, Decatur | |

American Association of Medical Assistants Illinois Society

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society, AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending Medical Assistant Programs are encouraged to belong. Physician advisors at all three levels assist with educational endeavors.

The state society's numerous professional, educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are:

Traveling Course Regional Seminars, Annual Symposium, Personal Development Day and the All Day Workshop held in conjunction with Chicago Medical Society's Midwest Clinical Conference. The Annual three day meeting in April includes excellent lectures, study programs and the culmination of association business during the House of Delegates Session.

The American Association of Medical Assistants encourages advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, administrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. Specialty examinations are given in Administrative, Clinical and Pediatric divisions. For further information about this program contact the American Association of Medical Assistants, One East Wacker Drive, Chicago, Illinois 60601.

Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks. The president of the Illinois Society communicates, via the "Executive Memo" (a monthly publication), with nearly 1,000 mem-

bers giving pertinent information of current activities.

A quarterly publication "The Illini Cardinal" concentrates on educational topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for non-members. There are many other benefits available (i.e. group insurance). During the Annual Meeting of AAMA each fall, a variety of experts in medical and related fields address participants during educational programs and workshops.

Monthly educational meetings are scheduled in the following chapters: Cook County-Chicago (downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), Northshore (Skokie), West Cook (River Grove), Cook County South (Dolton), Aux Plaines (Oak Park), DuPage (Wheaton), Coles-Cumberland (Charleston), DeKalb (Sycamore), Jefferson-Hamilton (Mt. Vernon), Kane (Elgin), LaSalle, Macon (Decatur), McLean (Bloomington), McHenry, Morgan-Scott (Jacksonville), Randolph (Chester), Rock Island, Sangamon (Springfield), St. Clair (Belleville), Spoon River Valley (Canton), Vermilion (Danville), Will-Grundy (Joliet), Shawnee (Harrisburg). Physicians in these areas are asked to encourage their medical assistants to join the association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

For membership information please contact Mrs. Leslie Lee, President, Illinois Society, AAMA, 5826 N. Whipple, Chicago, IL 60659.

OFFICERS

President—Mrs. Leslie Lee, Chicago
President-Elect—Mrs. Cissy (Moran) Egly, CMA, Joliet
Immediate Past President—Mrs. Vivian Kraft, CMA-AC, Bloomington
First Vice President—Mrs. Jean Lockenvitz, Bloomington
Second Vice President—Mrs. Anna Albert, Chicago
Recording Secretary—Ms Judith A. Miller, CMA-AC, Itasca
Corresponding Secretary—Mrs. Linda (Katek) Blazer, Chicago
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Vice Speaker of the House—Miss Pauline Klarich, Peoria
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Thomas R. Harwood, M.D., Chicago
Leslie Schwartz, M.D., Chicago
Robert Hartman, M.D., Jacksonville
J. M. Ingalls, M.D., Paris, *Liaison to ISMS*

The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

- 1) The initiation of scientific and medical research activities.
- 2) The collection, evaluation and dissemination of the results of research activities to the public.
- 3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which

has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

Board of Directors

George T. Wilkins, Granite City, *Chairman*
Audley F. Connor, Jr., Chicago
David S. Fox, Chicago
Robert R. Hartman, Jacksonville
P. John Seward, Rockford

STAFF: Division of Education, Manpower and Convention Services.

Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in co-operation with the state's eight medical schools, to fulfill six purposes: (a) make readily available to all Illinois physicians CME programs that will enhance patient care; (b) catalog and co-ordinate existing programs to eliminate wasteful duplication; (c) encourage development of new CME methods, techniques, and systems; (d) help identify the learning needs of Illinois physicians; (e) seek out potential CME providers and serve as liaison between producers and consumers; and (f) encourage Illinois physicians to participate in formal CME programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Following careful study, the 1970 House of Delegates approved the

plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as Chairman of the Organizing Committee. The Illinois Association of Osteopathic Physicians & Surgeons also offers financial support for ICCME.

ICCME was officially chartered by the state as a non-profit educational organization in May, 1972, and began operations with the appointment of its first Executive Director in September, 1972.

ICCME is unique in three respects: (1) it is the only such organization supported by a state medical society and staffed by a full-time professional educator; (2) it unites the educational resources of the Illinois State Medical

Society and the state's medical schools; and (3) independent in action, it serves *all* interests concerned with CME and thus provides a crucial channel of communication to co-ordinate the efficient use of all available resources.

Current Major Activities:

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois health-care system in the Council's work. The fifth Congress meets April 21-22, 1978.
2. On behalf of ISMS, perform staff work for accreditation of intra-state CME including advice on preparing to apply for accreditation.
3. Advise hospitals and other organizations on effective CME—both informally and through the "Illinois Hospital CME Consultation Service."
4. Organize workshops on techniques of CME—including an unusual "Workshop on CME Leadership" for leaders of hospital medical staffs and medical societies.
5. Develop and publish CME planning aids that offer practical advice and important background on effective organization of CME. Included are *Your Per-*

sonal Learning Plan, a unique handbook offering advice on how to plan your learning most effectively; and *How to Start a CME Program in Your Hospital or Medical Society* for CME planners. For all items now available, request "The Illinois Handbooks on CME Planning—Catalog/Order Form." All publications are free to Illinois physicians-M.D. or D.O.—upon request; just write the title on your prescription form and mail to ICCME, 55 E. Monroe, Chicago, IL 60603.

6. Publish an *Illinois CME Case Compendium* for hospital CME case-discussion groups.
7. Publish a monthly calendar of Illinois CME activities for *IMJ*.

Organization & Governance

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of: eight practicing physicians selected by the ISMS Board of Trustees; eight academic physicians, one selected by each dean of an Illinois medical or osteopathic school; plus the chairman of the ISMS Committee on CME Accreditation.

Board of Directors

William Lees, Lincolnwood, *President*
 Donald F. Pochly, Chicago, *Vice-President*
 Ward E. Perrin, Chicago, *Secretary*
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 EXECUTIVE DIRECTOR: Leonard S. Stein, Ph.D.

COMMITTEE ON ACCREDITATION

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 Philip D. Anderson, Chicago
 Allan C. Campbell, M.D., Peoria
 Julius S. Newman, Aurora
 H. Close Hesseltine, M.D., Chicago, *Consultant*

STAFF: Illinois Council on Continuing Medical Education

Responsibilities and Purposes:

To review reports of institutions which have applied for accreditation of their continuing medical education activities and make recommendations to the national Liaison Committee on Continuing Medical Education. To provide liaison with the Illinois Council on Continuing Medical Education.

ILLINOIS CME SPONSORS ACCREDITED BY THE LIAISON COMMITTEE ON CONTINUING MEDICAL EDUCATION AS OF AUGUST 31, 1978

The Academy of Cutaneous Surgery—River Forest
 Alfred Adler Institute of Chicago, Inc.
 Augustana Hospital—Chicago
 Belleville Hospital Association for CME
 (Memorial Hospital, St. Elizabeth Hospital)
 Carle Foundation Hospital—Urbana
 Central Community Hospital—Chicago
 Central DuPage Hospital—Winfield
 Chicago College of Osteopathic Medicine
 Chicago Pediatric Society
 Chicago Surgical Society
 Christ Hospital—Oak Lawn

Columbus-Cuneo-Cabrini Medical Center—Chicago
 Copley Memorial Hospital—Aurora
 Cook County Hospital—Chicago
 DuPage County Medical Society—Lombard
 Elgin Mental Health Center
 FAB³-CME (Forkosh Memorial, Belmont Community,
 Bethesda, Bethany Methodist, Thorek Medical
 Center) Chicago
 Forest Hospital—Des Plaines
 Grant Hospital of Chicago
 Henrotin Hospital—Chicago
 Hinsdale Sanitarium & Hospital

Holy Cross Hospital—Chicago	Resurrection Hospital—Chicago
Illinois Central Community Hospital—Chicago	Riveredge Hospital—Forest Park
Illinois Council on Continuing Medical Education—Chicago	Riverside Hospital—Kankakee
Illinois Heart Association—Springfield	Rock Island Franciscan Medical Center
Illinois Hospital Association—Oak Brook	Roosevelt Memorial Hospital—Chicago
Illinois Masonic Medical Center—Chicago	Rush Medical College—Chicago
Illinois Society of Allergy and Clinical Immunology—Highland Park	Sarah Bush Lincoln Health Center—Mattoon
Illinois Society of Ophthalmology and Otolaryngology—Danville	Sherman Hospital—Elgin
Kishwaukee Community Hospital—DeKalb	Silver Cross Hospital—Joliet
Little Company of Mary Hospital—Evergreen Park	Skokie Valley Community Hospital—Skokie
Louise Burg Hospital—Chicago	South Chicago Community Hospital
Loyola University Stritch School of Medicine—Maywood	Southern Illinois Medical Association—Belleville
Lutheran General Hospital—Park Ridge	Southern Illinois University School of Medicine—Springfield
MacNeal Memorial Hospital—Berwyn	St. Anthony Hospital—Chicago
Manteno State Hospital	St. Anthony Hospital—Rockford
Martha Washington Hospital—Chicago	St. Elizabeth's Hospital—Chicago
Mary Thompson Hospital—Chicago	St. Elizabeth Hospital—Danville
Memorial Hospital of DuPage County—Elmhurst	St. Elizabeth—Granite City
Mercy Hospital & Medical Center—Chicago	St. Francis Hospital—Medical Center—Peoria
The Methodist Medical Center of Illinois—Peoria	St. Joseph Hospital—Chicago
Michael Reese Hospital & Medical Center—Chicago	St. Joseph Hospital—Elgin
Mount Sinai Hospital Medical Center of Chicago	St. Mary's Hospital—Streator
Northwestern University Medical School—Chicago	St. Mary of Nazareth Hospital—Chicago
North Shore Mental Health Association/Irene Josselyn Clinic—Northfield	St. Therese Hospital—Waukegan
Northwest Hospital—Chicago	Swedish American Hospital—Rockford
Northwest Community Hospital—Arlington Heights	Swedish Covenant Hospital—Chicago
Norwegian-American Hospital—Chicago	Tinley Park Mental Health Center
Oak Forest Hospital	University of Chicago Pritzker School of Medicine
Oak Park Hospital	University of Health Sciences/The Chicago Medical School
Ravenswood Hospital Medical Center—Chicago	University of Illinois College of Medicine
	Weiss Memorial Hospital—Chicago
	Westlake Community Hospital—Melrose Park
	West Suburban Hospital—Oak Park

Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care (IFMC) is a not-for-profit corporation established in 1971 by action of the House of Delegates. Under revised bylaws adopted June, 1977, IFMC is operated under direction of a 6-member Board of Directors elected annually by the ISMS Board of Trustees. The IFMC currently contracts with

the Regional Health Resources Center, Urbana, Illinois for administrative services.

IFMC maintains relationships with the several local foundations for medical care and is available to serve their needs on a cost reimbursement basis.

IFMC Board of Directors

Joseph Sherrick, M.D., Chicago, *President*
 Robert P. Johnson, M.D., Springfield, *Vice-President*
 James Laidlaw, M.D., Champaign, *Secretary-Treasurer*

Audley F. Connor, M.D., Chicago
 Miller Henderson, M.D., Rockford
 Lawrence L. Hirsch, M.D., Chicago

Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their spouses. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his spouse can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the

Illinois General Assembly and in the U. S. Congress. It cooperates in membership solicitation activities with the American Medical Political Action Committee (AMPAC).

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 3510, 55 E. Monroe, Chicago 60603.

Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services is an Illinois corporation, formed in March, 1976, all of whose capital stock is owned by the Illinois State Medical Society. Its sole business is to act as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

The Exchange was organized to provide comprehensive professional liability insurance for Illinois physicians. Its membership is limited to members of the Illinois State Medical Society.

Insurance Services provides all the management and underwriting services required for the operation of the insurance business of the Exchange. It does so under Power-of-Attorney granted it by the Exchange in a management agreement with an initial term of five years, and by each member of the Exchange through his application for membership. Under the management agreement the Board of Governors of the Exchange prescribes policy to be followed in the conduct of the business; within the guidelines established by these policy statements, Insurance Services manages the business of the Exchange, accepting or rejecting applications, determining the form of insurance policies, handling and disposing of claims, and performing all related functions. Insurance Services is compensated by the Exchange on the basis of expense reimbursement; it is not anticipated that Insurance Services will produce any operating profit.

The organization of Insurance Services comprises four

principal functional divisions: Risk Management and Underwriting, Claims, Policyholders and Public Relations, and Administrative Services. Advisory and consultative services are provided by member physicians through a review system organized and directed by the Medical Director of Insurance Services. Financial and accounting services are provided by staff of the Illinois State Medical Society, whose Business Manager serves as Controller of Insurance Services. The offices of Illinois State Medical Insurance Services, Inc., are at 55 East Monroe Street, Suite 3440, Chicago, Illinois 60603.

Board of Directors

Phillip D. Boren
Alfred Clementi
Robert T. Fox
Robert Hamilton
J. M. Ingalls
Warren D. Tuttle
Roger N. White

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Robert T. Fox, *Chairman*
Paul E. Singer, *President*
Henry Nussbaum, *Vice President*
Roger N. White, *Secretary-Treasurer*
Phillip D. Boren, *Medical Director*

Student Business Session

Daniel R. Shirey, Maywood (Loyola) *Chairman*
W. Joseph Ketcherside, Chicago (University of Chicago)
Vice Chairman and Treasurer
Jerry Cohen, Chicago (Northwestern) *Secretary*
David Aizuss, Chicago (Northwestern) *Delegate*
Jason Chao, Chicago (Northwestern) *Alternate Delegate*
John Johnson, Forest Park (Loyola)
Immediate Past Chairman

School Representatives

Chicago Medical School
Phil Dray, Wilmette
Loyola University
Kenneth Stein, Oak Brook
Northwestern University
John Deseris, Chicago

Rush Medical School
David Fletcher, Oak Park
Southern Illinois University
David Roszhart, Springfield
University of Chicago
Don Henry, Chicago
University of Illinois
Robert Bryg, Chicago

The purposes of the Student Business Session shall be to encourage and support the active participation of medical students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Student Business Session shall support the purposes of ISMS as stated in its constitution. The Student Business Session is composed of all student members of ISMS.

Resident Physicians Section

Ira Isaacson, Chicago, *Chairman*
Michael Sadove, Chicago, *Vice Chairman and Treasurer*
Linda Hughey, Wilmette, *Secretary and Editor*
James DeBord, Oak Park, *Delegate*
Anthony Savino, Chicago, *Alternate Delegate*

House Staff Organization Representatives

The Children's Memorial Hospital
Cindy Moody and Abby Adams, Chicago
Illinois Masonic Medical Center
Brett Cassens, Chicago
Illinois State Psychiatric Institute
Stephen R. Cann, Chicago
Institute for Juvenile Research
Saroj Goyal, Chicago
Lutheran General Hospital
David Cooke, Park Ridge
Peoria School of Medicine/Methodist Medical Center
Leslie E. Mathers, III, Peoria
Rockford School of Medicine/Swedish American Hospital
Dennis P. Zoller, Rockford
Rush-Presbyterian-St. Luke's Medical Center
Benjamin L. LeCompte, III, Chicago
Scott Medical Center
C. A. Schuler, Scott AFB

St. Francis Hospital (Evanston)
James Zimmerman, Evanston
St. Francis Hospital Medical Center
Richard O'Connor, Peoria
St. Joseph Hospital
William Manns, Chicago
SIU School of Medicine/Carbondale
Roger Wujek, Carbondale
SIU School of Medicine/Springfield
James Apesos, Springfield
Swedish Covenant Hospital
Ira Moskowitz, Chicago
University of Illinois Hospital
James McCreary, Oak Park
Veterans Administration/North Chicago
Krishna Venu, North Chicago

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physicians Section shall support the purposes of the ISMS, as stated in its constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.

MEDICAL AND ALLIED HEALTH EDUCATION

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School, University of Health Sciences
2020 W. Ogden Ave., Chicago, 60612
Northwestern University Medical School
303 E. Chicago Ave., Chicago, 60611
University of Chicago-Pritzker School of Medicine
950 E. 59th Street, Chicago 60637
University of Illinois College of Medicine*
Chicago Campus—
1853 W. Polk Street, Chicago, 60612

Loyola University, Stritch School of Medicine
2160 S. First Ave., Maywood, 60153
Rush Medical College
1725 W. Harrison St., Chicago 60612
Southern Illinois University School of Medicine
801 N. Rutledge, P.O. 3926, Springfield, 62708

*Note: This is the parent college for Abraham Lincoln School of Medicine, Peoria School of Medicine, Rockford School of Medicine.

ALLIED HEALTH EDUCATIONAL PROGRAMS
 accredited by the
American Medical Association Committee on
Allied Health Education and Accreditation

CYTOTECHNOLOGIST

CHICAGO—Michael Reese Hospital & Medical Center
 Mount Sinai Hospital Medical Center
 University of Chicago—Lying-in-Hospital

HISTOLOGIC TECHNICIAN

CHICAGO—Mercy Hospital & Medical Center
 Mount Sinai Hospital & Medical Center
 St. Joseph Hospital
 University of Chicago Hospitals & Clinics
 SPRINGFIELD—St. John's Hospital

MEDICAL ASSISTANTS

BELLEVILLE—Belleville Area College
 CARTHAGE—Robert Morris School
 PALATINE—William Rainey Harper College
 RIVER GROVE—Triton College

MEDICAL LABORATORY TECHNICIAN

BELLEVILLE—Belleville Area College
 DANVILLE—St. Elizabeth Hospital
 DIXON—Sauk Valley College
 EAST PEORIA—Illinois Central College
 ELGIN—Sherman Hospital Association
 GODFREY—Lewis & Clark Community College
 MORTON GROVE—Oakton Community College
 OLNEY—Richland Memorial Hospital
 PALOS HILLS—Moraine Valley Community College
 QUINCY—Blessing Hospital
 RIVER GROVE—Triton College

MEDICAL RECORD ADMINISTRATORS

CHICAGO—University of Illinois College of Medicine
 NORMAL—Illinois State University

MEDICAL RECORD TECHNICIAN

BELLEVILLE—Belleville Area College
 CHICAGO—Central YMCA Community College
 EAST PEORIA—Illinois Central College
 GRAYSLAKE—College of Lake County
 MORTON GROVE—Oakton Community College
 PALOS HILLS—Moraine Valley Community College

MEDICAL TECHNOLOGIST

BELLEVILLE—St. Elizabeth Hospital
 BLUE ISLAND—St. Francis Hospital
 CHAMPAIGN—Burnham City Hospital
 CHICAGO—Augustana Hospital & Health Care Center
 Grant Hospital of Chicago
 Holy Cross Hospital
 Illinois Masonic Medical Center
 Louis A. Weiss Memorial Hospital
 Mercy Hospital & Medical Center

Michael Reese Hospital & Medical Center
 Northwestern University Medical School
 Rush-Presbyterian-St. Luke's Medical Center
 St. Anne's Hospital
 St. Anthony Hospital
 St. Joseph Hospital
 St. Mary of Nazareth Hospital Center
 University of Illinois College of Medicine
 V. A. Lakeside Hospital

DANVILLE—Lake View Memorial Hospital
 DECATUR—Decatur Macon County Hospital
 St. Mary's Hospital

EVANSTON—Evanston Hospital

FREEPORT—Freeport Memorial Hospital

GENEVA—Community Hospital

GREAT LAKES—U.S. Naval Regional Medical Center

HINES—V.A. Hospital

HINSDALE—Hinsdale Sanitarium & Hospital

JOLIET—Silver Cross Hospital

St. Joseph Hospital

MAYWOOD—Foster G. McGaw Hosp./Loyola University

NORTH CHICAGO—University of Health Sciences/
 Chicago Medical School

OAK LAWN—Christ Community Hospital

OAK PARK—West Suburban Hospital Association

PARK RIDGE—Lutheran General Hospital

PEORIA—Methodist Medical Center of Central Illinois

St. Francis Hospital

QUINCY—St. Mary's Hospital

ROCKFORD—Rockford Memorial Hospital

St. Anthony Hospital

Swedish-American Hospital

SPRINGFIELD—St. John's Hospital

Sangamon State University

URBANA—Carle Foundation Hospital

WAUKEGAN—St. Therese Hospital

WINFIELD—Central DuPage Hospital

NUCLEAR MEDICINE TECHNOLOGY

CHICAGO—Northwestern Memorial Hospital
 St. Mary of Nazareth Hospital Center

EVANSTON—Evanston Hospital

HINES—V. A. Hospital

PARK RIDGE—Lutheran General Hospital

RIVER GROVE—Triton College

OPERATING ROOM TECHNICIAN

BELLEVILLE—Belleville Area College

CHAMPAIGN—Parkland College

EAST PEORIA—Illinois Central College

MOLINE—Lutheran Hospital

PALOS HILLS—Moraine Valley Community College

QUINCY—Blessing Hospital

RIVER GROVE—Triton College

OCCUPATIONAL THERAPIST

CHICAGO—University of Illinois College of Medicine

PHYSICAL THERAPIST

CHICAGO—Northwestern University Medical School
University of Health Science/
Chicago Medical School
University of Illinois College of Medicine

RADIOLOGIC TECHNOLOGIST

ARLINGTON HTS.—Northwest Community Hospital

BELLEVILLE—Belleville Area College

CENTRALIA—St. Mary's Hospital

CHAMPAIGN—Parkland College

CHICAGO—Central YMCA Community College
Cook County Hospital
DePaul University
Henrotin Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Malcolm X Community College
Michael Reese Hospital & Medical Center
Provident Hospital & Training School
Ravenswood Hospital Medical Center
St. Anne's Hospital
St. Joseph Hospital
St. Mary of Nazareth Hospital Center
South Chicago Community Hospital
University of Illinois Hospital
Woodlawn Hospital
Wright Junior College

DANVILLE—Lake View Medical Center

DECATUR—Decatur Macon County Hospital

DIXON—Sauk Valley College

EAST PEORIA—Illinois Central College

ELGIN—St. Joseph Hospital

EVANSTON—St. Francis Hospital

GALESBURG—Carl Sandburg College

GLEN ELLYN—College of DuPage

GRAYSLAKE—College of Lake County

HINSDALE—Hinsdale Sanitarium & Hospital

KANKAKEE—Kankakee Community College

KEWANEE—Kewanee Public Hospital

MACOMB—McDonough District Hospital

MALTA—Kishwaukee College

MOLINE—Lutheran Hospital; Moline Public Hospital

MORTON GROVE—Oakton Community College

NORMAL—Bloomington-Normal School of
Radiologic Technology

OLNEY—Richland Memorial Hospital

PALOS HILLS—Moraine Valley Community College

PEORIA—St. Francis Hospital

QUINCY—Blessing Hospital
St. Mary's Hospital

RIVER GROVE—Triton College

ROCKFORD—Rockford Memorial Hospital
Swedish American Hospital

ROCK ISLAND—Rock Island Franciscan Hospital

SOUTH HOLLAND—Thornton Community College

SPRINGFIELD—Lincoln Land Community College
Memorial Medical Center

RESPIRATORY THERAPIST

CHAMPAIGN—Parkland College

CHICAGO—Central YMCA Community College
Malcolm X College
Northwestern University affiliated hospitals
University of Chicago Hospitals & Clinics

MOLINE—Lutheran Hospital

PALOS HILLS—Moraine Valley Community College

RIVER GROVE—Triton College

ROCKFORD—St. Anthony Hospital

SPRINGFIELD—Memorial Medical Center

RESPIRATORY THERAPY TECHNICIAN

CHAMPAIGN—Parkland College

CHICAGO—Northwestern Memorial Hospital
University of Chicago Hospitals and Clinics

MOLINE—Lutheran Hospital

PALOS HILLS—Moraine Valley Community College

QUINCY—St. Mary's Hospital

ROCKFORD—Swedish American Hospital

SPRINGFIELD—St. John's Hospital

WAUKEGAN—Victory Memorial Hospital

RADIATION THERAPY TECHNICIAN

CHICAGO—Rush-Presbyterian-St. Luke's Medical Center

ELGIN—St. Joseph Hospital

EVANSTON—Evanston Hospital

HINES—V. A. Hospital

MOLINE—Luthern Hospital

ROCKFORD—Swedish American Hospital

SPECIALIST IN BLOOD BANK TECHNOLOGY

CHICAGO—Mount Sinai Hospital Medical Center
University of Illinois College of Medicine

SPRINGFIELD—St. John's Hospital

PARK RIDGE—Lutheran General Hospital

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 59 Legislative Districts. Each district elects one senator and three representatives. Thus, the Senate has 59 members and the House 177. Under the new constitution, senators are elected for 4 year terms, representatives are elected for 2 year terms.

The General Assembly shall convene each year on the second Wednesday of January. The General Assembly shall be a continuous body during the term for which members of the House of Repre-

sentatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for

four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They shall be elected at the general election in 1976 and 1978 and every four years thereafter.

STATE OFFICERS 1977

Governor, JAMES R. THOMPSON, Rep., Chicago

Lieutenant Governor, DAVE O'NEAL, Rep.,
Belleville

Secretary of State, ALAN J. DIXON, Dem., Belleville

Comptroller, MICHAEL J. BAKALIS, Dem.,
Downers Grove

Treasurer, DONALD R. SMITH, Rep., Springfield
Attorney General, WILLIAM J. SCOTT, Rep.,
Evanston

Clerk of the Supreme Court, CLELL L. WOODS,
Springfield

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading after which it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out

the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he will sign it. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The Governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 701 S. Second St., Springfield 62704.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

160 North LaSalle Street, Room 315, Chicago
One North Old State Capitol Plaza, Springfield
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John Ryan, *Executive Deputy Director*

Director's Office

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John Petrilli, Director of Technical Assistance and
Monitoring

Peter Digre, Director of Planning, Research and
Evaluation
Gary Anderson, Director of Management Services
Paul Freedlund, Administrative Assistant to the Director
(Springfield)
Steve Bishop, Administrative Assistant to the Director
(Chicago)

DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

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160 N. La Salle St., Chicago, 60601
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Ivan Pavkovic, M.D., Associate Director

Richard E. Blanton, Ph.D., Associate Director, Developmental Disabilities Services
Noble Emde, Administrator for Management Services
Edwin Goldman, Administrator for Community Services & Interagency Affairs
Roalda Alderman, Superintendent of Alcoholism & Dangerous Drugs Liaison

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Meyer Proctor, Chief, Office of Public Information
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David Klass, M.D., Research Director
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James Dalzell, Region 1B Administrator, Peoria
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DANGEROUS DRUGS COMMISSION

The Drug Abuse Offense and Treatment Act of 1972 (PL 92-255) made federal funds available to the states for the purpose of combating drug abuse. In order to receive such funds, a state must submit a plan for implementing and evaluating an effective program for drug abuse prevention, treatment, and rehabilitation. Further, a single state agency must be established as the sole agency for the preparation and administration of the plan and allocation of funds.

The Dangerous Drugs commission also licenses and regulates all drug treatment, education, prevention and rehabilitation programs in the state, except those conducted within a licensed hospital. The Commission sets treatment standards and issues rules and regulations for the operation of drug abuse programs.

Treatment modalities of programs receiving Dangerous Drugs Commission funds include methadone maintenance, both residential and out-patient; drug free residential and out-patient therapy, and hot-line and crisis referral services. In addition to treatment funding, the Dangerous Drugs Commission supports drug counselor training for

previously drug dependent clients as well as clinical staff training.

Since reliable and timely data are essential in evaluating the effectiveness of drug abuse treatment and rehabilitation methods, the Information Services Section of the Commission continually collects, analyzes and applies data concerning clinical operations (medical workups, demographics) and regulatory methadone maintenance (counseling, toxicology, prescription dosages.) The Section also keeps a weekly statewide log for methadone clinics, a continuing inventory of drug abuse program resources, and a bank of research data on treatment modalities. All information is strictly confidential.

The Toxicology Division of the Dangerous Drugs Commission is the state laboratory facility which provides drug abuse tests to the state's total client population. The lab is subject to the regulations and standards set by the FDA, the National Institute of Drug Abuse and the Commission itself.

The Dangerous Drugs Commission is located at Marina City Office Building, 300 N. State St., Suite 1500, Chicago, 60610. Phone (312) 822-9860.

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DEPARTMENT OF PUBLIC AID

316 South 2nd St., Springfield
Arthur F. Quern, *Director*

The Illinois Department of Public Aid administers the federally aided public assistance programs: Aid to Families with Dependent Children; Medical Assistance; and provides supplemental financial grants to eligible aged, blind, or disabled persons. In addition, the department allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp program.

Administrative Staff

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Jane Snowden, Special Assistant to the Director
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Public Health Laboratories

2121 West Taylor, Chicago, 60612
134 North 9th Street, Springfield 62706
P.O. Box 2467, Carbondale 62901

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(Allied with Public Health Operations)

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Advisory Committee for Family Practice Residency Act, HB 106, 107; P.A. 84-78, 84-79

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Penny Meyers, Skokie

POISON CONTROL CENTERS IN ILLINOIS

For information contact:
Division of Emergency Medical Services & Highway Safety
Illinois Department of Public Health
525 W. Jefferson
Springfield, 62761
Phone: (217) 782-5278

APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS

Illinois Department of Public Health Division of Disease Control

For information contact:

Mrs. Ruth S. Shriner, ACSW—Coordinator Direct Services
Programs, Illinois Department of Public Health,
Room 150, 535 West Jefferson Street, Springfield 62706
Phone (217) 782-3303

DEPARTMENT OF REGISTRATION AND EDUCATION

628 East Adams Street, Springfield
55 East Jackson Boulevard, Chicago

Joan G. Anderson, *Director*
Thomas Ortziger, *Assistant Director*
Jerry D. Sternstein, *Deputy Director-Licensing*
Jacob M. Shapiro, *Chief Counsel*
Algis Augustine, *Chief Regulatory Officer*

The department is primarily concerned with the registration, licensing and enforcement of 30 laws governing the different professions, trades and occupations, including the Medical Practice Act.

The Medical Examining Committee appointed by the director of the department operates within the framework of the act and is charged with the responsibility of supervising examinations for licensure and making recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

Medical Examining Committee

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Mays Maxwell, M.D., East St. Louis, *Vice-chairperson*
Paul Tullio, D.C., Glen Ellyn, *Secretary*
Charles Bobelis, M.D., Dundee
David Fox, M.D., Chicago
Robert Behmer, M.D., Rockford

Medical Disciplinary Board

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Levon Krikor Topouzian, M.D., Skokie
James B. Williams, M.D., Chicago
Raimundo Rodriguez, M.D., Murphysboro

MEDICAL PRACTICE ACT

Service on medical committees—Exemption from civil liability. § 2b. While serving upon any Medical Utilization Committee, Medical Review Committee, Patient Care Audit Committee, Medical Care Evaluation Committee, Quality Review Committee, Credential Committee, Peer Review Committee or any other committee whose purpose, directly or indirectly, is internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital duly licensed under the Hospital Licensing Act, or the improving or benefiting of patient care and treatment whether within a hospital or not, or for the purpose of professional discipline, any person serving on such committee, and any person providing service to such committees shall not be liable for civil damages as a result of his acts, omissions, decisions, or any other conduct in connection with his duties on such committees, except those involving willful or wanton misconduct. *Amended by P.A. 79-1434 § 7, eff. Sept. 19, 1976; P.A. 80-771, § 3, eff. Oct. 1, 1977.*

Practice by person licensed in another state pending examination. § 2c.

This act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the United States or the District of Columbia who has applied in writing to the Department, in form and substance satisfactory to the Department, for a license to practice medicine in all of its branches and has complied with all of the provisions of Section 13, except the passing of an examination which may be given under Section 13, until:

(a) the expiration of 6 months after the filing of such written application, or

(b) the decision of the Department that the applicant has failed to pass an examination within 6 months or failed without an approved excuse to take an examination conducted within 6 months by the Department, or

(c) the withdrawal of the application. (Added by Act approved July 26, 1971)

Dispensing drugs or medicine—Label.] § 2d.

Any person licensed under this Act who dispenses any drug or medicine shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the last name of the person dispensing such drug or medicine; (c) the directions for use thereof; and (d) the proprietary name or names or, if there is none, the established name or names of the drug or medicine, the dosage and quantity, unless the person dispensing the drug or medicine determines that the health of the person to whom the drug or medicine is dispensed requires that such information be omitted. This Section shall not apply to drugs or medicines in a package which bears a label of the manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug and Cosmetic Act and the Illinois Food, Drug and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. "Drug" and "medicine" have the meaning ascribed to them in the "Pharmacy Practice Act," approved July 11, 1955, as now or hereafter amended. Formerly § 2c. Renumbered § 2d by P.A. 77-1849, § 3, eff. July 1, 1972.

§ 2d5. *Minimum standards of professional education.* Except as provided in Section 9a of this Act, the minimum standards of professional education to be enforced by the department in conducting examinations and issuing licenses shall be as follows:

1. *Practice of Medicine.* For the practice of medicine in all of its branches:

(a) For an applicant who is a graduate of a medical college before the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to graduation a 4 years' course of instruction of not less than 9 months each, in such medical college, or its equivalent, the time elapsing between the beginning of the first year and the ending of the fourth year having been not less than 40 months, and which was reputable and in good standing in the judgment of the department; and prior to taking such examination said applicant must present proof that he has completed a 4 years' course of instruction in a high school or its equivalent as determined by an examination conducted by the department.

(b) For an applicant who is a graduate of a medical college after the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to admission thereto 2 years' course of instruction in a college of liberal arts, or its equivalent, or in such medical college, and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, and in addition thereto, a course of clinical training of not less than 12 months in a hospital, such college of liberal arts, medical college and hospital having been reputable and in good standing in the judgment of the department. The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the case of programs involving students

with advanced standing.

(c) For an applicant who is a graduate of a medical college or school in another country; that such applicant was a resident of this State for a period of five years prior to matriculating in such medical college or school; that such applicant completed a required course of instruction in the treatment of human ailments as offered by such college or school of medicine, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of three years' course of instruction in an accredited college of liberal arts or its equivalent; that such applicant submit an application to an Illinois medical school and submit to such testing procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school, to determine equivalency of education compared to state norms, such testing could be utilized in placement of such applicant at a level appropriate to educational achievement; that such applicant may be placed by an Illinois medical school into the appropriate level of medical school, thru internship training, provided that applicant agrees to pay, either by a scholarship or some other personal means, such tuition and fees necessary to complete medical education, and provided that such applicant signs a statement in a form to be determined by the Department that upon successful completion of all licensure requirements applicant intends to practice medicine in this State. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicant shall be eligible for award of an M.D. degree and examination and licensing for the practice of medicine in all of its branches as provided in this act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

(d) Until September 1, 1988, for an applicant who has studied medicine at a medical college or school located outside the United States; that such applicant has completed all of the formal requirements of a foreign medical school except internship and/or social service, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of 3 years' course of instruction in an accredited college of liberal arts or its equivalent; that such an applicant has submitted an application to a medical school recognized by the Department and submitted to such evaluation procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school and that such applicant has satisfactorily completed one academic year of supervised clinical training under the direction of such medical school; and, after completion of said academic year of supervised clinical training, that such applicant has satisfactorily completed twelve months of post graduate training in an approved hospital having been reputable and in good standing in the judgment of the Department; and provided that such applicant sign a statement and a form, to be determined by the Department, that upon successful completion of all license requirements, applicant intends to practice medicine in this state. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school,

applicants shall be eligible for examination and licensing for the practice of medicine in all of its branches as provided in this Act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

Until September 1, 1988, satisfaction of the requirements of this sub-section shall be in lieu of the completion of any foreign internship and/or social service requirements, and no such requirements shall be a condition of licensure as a physician in this State.

Until September 1, 1988, satisfaction of the requirements of this sub-section shall be in lieu of certification by the Educational Council for Foreign Medical Graduates, and such certification shall not be a condition of licensure as a physician in this State for candidates who have completed the requirements of this sub-section.

Until September 1, 1988, no hospital licensed by the State, or operated by the State or political subdivision thereof, or which receive State financial assistance, directly or indirectly, shall require an individual who at the time of his enrollment in a medical school outside the United States is a citizen of the United States, to satisfy any requirement other than those contained in this sub-section prior to commencing an internship or residency.

Until September 1, 1988, a document granted by a medical school located outside the United States which certifies completion of all of the formal training requirements of such foreign medical school except internship and/or social service; and satisfactory completion of the examination and academic year of supervised clinical training at a medical school recognized by the Department referred to in this sub-section shall be deemed the equivalent of the degree of Doctor of Medicine for purposes of licensure and practice as a physician in this State and shall possess all the rights and privileges thereof.

The Illinois Board of Higher Education may make grants to Illinois Medical Schools, public and private, for each applicant who commences his academic year of supervised clinical training under the direction of said medical school. Preference shall be given in the award of these grants to Illinois residents. The Illinois Board of Higher Education shall by regulation adopt reasonable guidelines for the distribution of funds authorized by this Act. (Added by Act approved Sept. 7, 1974).

2. Treating human ailments without drugs or medicines and without operative surgery. For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery:

(a) For an applicant who was a resident student and who is a graduate before July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments, which he specifically designated in his application as the one he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to graduation a 3 years' course of instruction of not less than 6 months each, the time elapsing between the beginning of the first year and the ending of the third year having been not less than 22 months, and which are reputable and in good standing in the judgment of the department and prior to taking the examination the applicant must present proof that he has completed a 4 years'

course of instruction in high school, or its equivalent, as determined by an examination conducted by the department.

(b) For an applicant who was a resident student and who is a graduate after July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application as the one which he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to admission thereto a 4 years' course of instruction in a high school, and as a prerequisite to graduation therefrom a course of instruction in the treatment of human ailments, of not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months except that as to students matriculating or entering upon a course of study of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery during the years 1940, 1941, 1942, 1943, 1944, 1945, 1946 and 1947, the said elapsed time shall be not less than 32 months, such high school and such school, college, institution having been reputable and in good standing in the judgment of the department.

(c) For an applicant who is a matriculant in a chiropractic college after September 1, 1969, that such applicant shall be required as a prerequisite for admission to examine for licensure, to complete a 2 years' course of instruction in a liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course as a prerequisite to graduation therefrom having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

3. Midwifery. For the practice of midwifery: That he be a graduate of a college of midwifery which requires as a prerequisite to admission thereto, a one year's course of instruction in a high school or its equivalent, and required as a prerequisite to graduation, a one year's course in such college of midwifery, the time actually spent under instruction in such college of midwifery to have been not less than 12 months; such high school or equivalent school, and such college of midwifery having been in good standing in the judgment of the department.

Without prejudice to licenses heretofore issued under this section, no further licenses shall be issued under this section after the effective date of this amendment. Amended by P.A. 80-368. § 1, eff. Oct. 1, 1977.

CONTINUING EDUCATION

Continuing education—Recommendations by Examining Committee]

The Department, based on the written recommendation of the Examining Committee, shall promulgate mandatory requirements of continuing education for persons licensed pursuant to this Act. In establishing such recommendations, the Committee shall:

(1) Develop practical and meaningful criteria for defining and describing continuing education

requirements which meet, but are not limited to, the following specifications:

- (a) Readily available to all practicing physicians in Illinois without undue commitment of time away from practice and expense on the part of the practitioner.
 - (b) Compatible with existing requirements of licensing agencies in other states.
 - (c) Compatible with the requirements of medical specialty boards for recertification of specialty status.
 - (d) Compatible with the continuing education requirements developed by national medical specialty societies.
 - (e) Compatible with continuing education programs and requirements that are developed in federally mandated peer review programs and as a part of Professional Standards Review Organizations.
 - (f) Provides for differing requirements for licensees engaged in other than direct patient care (example: educators, researchers and those engaged in medical administration).
 - (g) Provides for compatible requirements for licensees in the federal uniformed services, those engaged in formal residency and fellowship training programs, and licensees operating under hospital permit licensure.
- (2) Conceive, develop and evaluate procedures, materials and systems to carry out the administrative requirements of this legislation which include, but are not limited to, the following:
- (a) Procedures for prompt and fair evaluation of reports of educational achievement submitted by licensees.
 - (b) Requirements and position descriptions for personnel engaged in reviewing and evaluating reports and continuing educational achievements submitted by licensees.
 - (c) A data recording system for gathering, analyzing, storing and retrieving information on individual licensee educational accomplishments.
 - (d) Provision for licensee to appeal adverse actions and temporary exemptions from requirements under unusual circumstances.
 - (e) Exemption from legal prosecution of all persons responsible for action taken under the program.
 - (f) Establishment of realistic budgeting and cost requirements for the personnel, and operational funds necessary to plan, develop and operate the program.
 - (g) Procedures for surveying and evaluating the effectiveness of the program.
 - (h) Orderly procedures for adequate notice to licensee of pending action that may result in non-renewal of license, including provisions for consultation and assistance in time for him to meet the requirements of this Act.
- (3) Develop adequate protection for information about licensee participation in continuing education as it pertains to all aspects of practice liability and the licensee's public image and his relationships with individual patients.
- (4) Develop an advisory panel for each category of licensee to advise and assist the department in development and application of continuing education criteria, administrative procedures and policy.

- (5) Develop procedures for assuring that the educational opportunities available to licensees for fulfilling the requirements of this act are of appropriate scope, variety, depth and of high quality.

The Department shall enforce these requirements; however, the Department shall be empowered to waive enforcement of these requirements in localities where it is demonstrated that the absence of opportunities for such education would interfere with the adequacy of medical services in that locality. Added by P.A. 79-1136, §1, eff. July 1, 1976.

REVOCATION AND SUSPENSION OF LICENSE OR CERTIFICATE

Revocation and suspension of license or certificate—Grounds—Limitation—Insanity—Resumption of practice on restoration.]

The Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or State hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon the following grounds:

1. Performance of an elective abortion in any place, locale, facility, or institution other than:
 - (a) a facility licensed pursuant to the "Ambulatory Surgical Treatment Center Act" as heretofore or hereafter amended;
 - (b) an institution licensed pursuant to "An Act relating to the inspection, supervision, licensing and regulation of hospitals," approved July 1, 1953, as heretofore or hereafter amended; or
 - (c) an ambulatory surgical treatment center or hospitalization care facility maintained by the State or any agency thereof, where such department or agency has authority under law to establish and enforce standards for the ambulatory surgical treatment centers, hospitalization, or care facilities under its management and control, or
 - (d) ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government; or
 - (e) ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation;
2. Conviction in this or another state of any crime which is a felony under the laws of this State or conviction of a felony in a federal court, unless such person demonstrates

- to the Department that he has been sufficiently rehabilitated to warrant the public trust;
3. Gross or repeated malpractice resulting in serious injury or death of a patient;
 4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;
 5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury or any person can be permanently cured;
 6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties;
 7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;
 8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules and regulations of the department governing examinations;
 9. Holding one's self out to treat human ailments by making false statements or by specifically designating any disease, or group of diseases and making false claims of one's skill, or the efficacy or value of one's medicine, treatment or remedy therefore;
 10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;
 11. Revocation or suspension of a medical license in a sister state;
 12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;
 13. Except as otherwise provided in Section 16.01, advertising or soliciting by himself or through another, by means of handbills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business.
 14. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in

partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act" as now or hereafter amended or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of two or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divide a fee: provided, the patient has full knowledge of the division, and provided that the division is made in proportion to the services performed and responsibility assumed by each.

15. A finding by the Medical Disciplinary Board that the registrant after having his license placed on probationary status violated the terms of the probation.
16. All advertising of medical business which is intended, or has a tendency, to deceive the public or impose upon credulous or ignorant persons and so be harmful or injurious to public morals or safety.
17. All advertising of any medicine or of any means whereby the monthly menses of women can be regulated or reestablished if suppressed.
18. Abandonment of a patient.
19. The use of prescription for use of narcotics or controlled substances (designated products) in any way other than for therapeutic purposes.
20. Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician.
21. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department of Registration and Education.
22. Immoral conduct in practice as a physician, or repeated acts of gross misconduct.
23. Willfully making or filing false records or reports in his practice as a physician.
24. Willful omission to file or record, or willfully impeding the filing or recording or inducing another person to omit to file or record medical reports as required by law.
25. Solicitation of professional patronage by any corporation, agents or persons, or profiting from those representing themselves to be agents of the licensee.
26. Gross and willful and continued overcharging for professional services, including filing false statement for collection of fees for which services are not rendered.
27. Professional incompetence as manifested by poor standards of care or mental incompetency as declared by a court of competent jurisdiction.
28. Physical illness, including, but not limited to,

deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill or safety.

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license, certificate or state hospital permit on any of the foregoing grounds, except the ground numbered 8 (fraudulent groups expected) must be commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license, certificate or state hospital permit was without the State of Illinois shall not be included within the 3 years.

The entry of an order or judgment by any circuit court establishing that any person holding a license, certificate or state hospital permit under this Act is a person in need of mental treatment operates as a suspension of that license, certificate or state hospital permit. That person may resume his practice only upon a finding by the Medical Disciplinary Board that he has been determined to be recovered from mental illness by the court and upon the Board's recommendation that he be permitted to resume his practice.

Amended by P.A. 79-1130, § ; [Nov. 2] 21. 1075, P.A. 79-13 1434, § eff. Sept. 19, 1976.

Listing of name, title, etc.

Section 16.01. Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone number, residence address and phone number and any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business, absence from, or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type.

Added by act approved July 18, 1967.

MEDICAL DISCIPLINARY BOARD

Illinois State Medical Disciplinary Board.] § 16.02.

There is hereby created the Illinois State Medical Disciplinary Board, (hereinafter referred to as the "Board"). The Board shall consist of 7 members, appointed by the Governor by and with advice and consent of the Senate. All shall be residents of the State, not more than 4 of whom shall be members of the same political party. Five members shall be physicians licensed to practice medicine in all of its branches in Illinois. One member shall be an Illinois physician possessing the degree of doctor of

osteopathy. One member shall be a person licensed in Illinois and possessing a chiropractor's degree.

a. Of the members of the Board first appointed, two shall be appointed for terms of 2 years, two shall be appointed for terms of 3 years, and three shall be appointed for terms of 4 years. Upon the expiration of the term of any member, his successor shall be appointed for a term of four years by the Governor by and with the advice and consent of the Senate. The Governor shall fill any vacancy for the remainder of the unexpired term by and with the advice and consent of the Senate. Upon recommendation of the Board, any member of the Board may be removed by the Governor for misfeasance, malfeasance, or willfull neglect of duty after notice and a public hearing unless such notice and hearing shall be expressly waived in writing. Each member shall serve on the Board until his successor is appointed and qualified. No member of the Board shall serve more than two consecutive four year terms.

In making appointments the Governor shall attempt to insure that the various social and geographic regions of the State of Illinois are properly represented.

In making the designation of persons to act for the several professions represented on the Board, the Governor shall give due consideration to recommendations by members of the respective professions and by organizations therein.

- b. The Board shall annually elect one of its members as chairman, one as vice chairman and one as secretary. No officer shall be elected more than twice in succession to the same office. Each officer shall serve until his successor has been elected and qualified.
- c. The secretary shall keep a record of the proceedings of the Board and shall be custodian of all books, documents and papers filed with the Board, including the minute book or journal of the Board. The secretary or other persons authorized by the Board may cause copies to be made of all minutes and other records and documents of the Board and may give certificates of the Board to the effect that such copies are true copies, and all persons dealing with the Board may rely upon such certificates.
- d. Four members of the Board shall constitute a quorum. A vacancy in the membership of the Board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the Board. Any action taken by the Board under this Act may be authorized by resolution at any regular or special meeting and each such resolution shall take effect immediately. The Board shall meet at least quarterly. The Board is empowered to adopt all rules and regulations necessary and incident to the powers granted to it under this Act.
- e. Each member, and member-officer, of the Board shall receive a per-diem stipend as the Director of the Department of Registration and Education, hereinafter referred to as the Director, shall determine. Each member shall be paid his necessary expenses while engaged in the performance of his duties.
- f. The Director shall, in conformity with the "Personnel Code," as now or hereafter amended, select a medical coordinator, who shall not be a member of the Board. The medical coordinator shall be a physician licensed to practice medicine

in all of its branches, and the Director shall set his rate of compensation. The medical coordinator shall be the chief enforcement officer of the Medical Practice Act and shall serve at the will of the Board.

The Director shall employ, in conformity with the Personnel Code, not less than one (1) full time investigator for every 5000 physicians licensed to practice medicine in the State. Each investigator shall be a college graduate with at least two years' investigative experience or one year advanced medical education. Upon the written request of the Board, the Director shall employ, in conformity with the Personnel Code, such other professional, technical, investigative, and clerical help, either as a full or part-time basis as the Board deems necessary for the proper performance of its duties. All employees of the Board shall be directed by, and answerable to, the Board with respect to their duties and functions.

- g. Upon the specific request of the Board, signed by either the chairman, vice chairman, or medical coordinator of the Board, the Bureau of Drug Compliance, the Office of Professional Supervision of the Department of Registration and Education, the Illinois Law Enforcement Commission, the Illinois Bureau of Investigation, the Illinois Legislative Investigating Commission shall:

(1) Make available any and all information that they shall have in their possession regarding a particular case then under investigation by the Board.

- h. Members of the Board shall be immune from suit in any action based upon any disciplinary proceedings of other acts performed in good faith as members of the Board.

Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Suspension or revocation of license or certificate—Investigation—Notice—Hearing.] § 17.01 Upon the motion of either the Department or the Board or upon the verified complaint in writing of any person setting forth facts which if proven would constitute grounds for suspension or revocation under Section 16 of this Act, the Department shall, through the Board, investigate the actions of any person, so accused who holds or represents that he holds a license or certificate. Such person is hereinafter called the accused.

The Department shall, before suspending, revoking, placing on probationary status, or taking any other disciplinary action as the Department may deem proper with regard to any license or certificate, at least 30 days prior to the date set for the hearing, notify the accused in writing of any charges made and the time and place for a hearing of the charges before the Board, direct him to file his written answer thereto the Board under oath within 20 days after the service on him of such notice and inform him that if he fails to file such answer default will be taken against him and his license or certificate may be suspended, revoked, placed on probationary status, or have other disciplinary action, including limiting the scope, nature or extent of his practice, as the Department may deem proper taken with regard thereto.

Such written notice and any notice in such proceedings thereafter may be served by delivery of the same personally to the accused person, or by mailing the same by registered or certified mail to

the address last theretofore specified by the accused in his last notification to the Department. *Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

Hearings by board—Continuance—Failure to file answer—Disciplinary action—Temporary suspension of license without hearing.] § 17.02 At the time and place fixed in the notice, the Board provided for in this Act shall proceed to hear the charges and both the accused person and the complainant shall be accorded ample opportunity to present in person, or by counsel, such statements, testimony, evidence and argument as may be pertinent to the charges or to any defense thereto. The Board may continue such hearing from time to time. If the Board is not sitting at the time and place fixed in the notice or at the time and place to which the hearing has been continued, the Department shall continue such hearing for a period not to exceed 30 days.

In case the accused person, after receiving notice, fails to file an answer, his license or certificate may in the discretion of the Director, having received first the recommendation of the Board, be suspended, revoked, placed on probationary status, or the Director may take whatever disciplinary action as he may deem proper, including limiting the scope, nature, or extent of said person's practice, without a hearing, if the act or acts charged constitute sufficient grounds for such action under this Act.

The Board has the authority to recommend to the Director that probation be granted or that other disciplinary action, including the limitation of the scope, nature or extent of a person's practice, be taken as it deems proper. If disciplinary action other than suspension or revocation is taken, the Board may recommend that the Director impose reasonable limitations and requirements upon the accused registrant to insure compliance with terms of the probation or other disciplinary action including, but not limited to, regular reporting by the accused to the Department of his actions, placing himself under the care of a qualified physician for treatment, or limiting his practice in such manner as the Director may require.

The Director may temporarily suspend the license of a physician without a hearing, simultaneously with the institution of proceedings for a hearing provided under this Section if the Director finds that evidence in his possession indicates that a physician's continuation in practice would constitute an immediate danger to the public. In the event that the Director suspends, temporarily, the license of a physician without a hearing, a hearing by the Board must be held within 15 days after such suspension has occurred.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Subpoena of witnesses—Administration of oath.] § 17.03 The Board or Department has power to subpoena and bring before it any person in this State and to take testimony either orally or by deposition, or both, with the same fees and mileage and in the same manner as is prescribed by law for judicial procedure in civil cases.

The Director, Assistant Director, Superintendent of Registration and any member of the Board each have power to administer oaths at any hearing which the Board or Department is authorized by law to conduct.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Attendance of witnesses and production of books and papers.] § 17.04 Any circuit court upon the application of the accused person or complainant or of the Department or Board, may order the attendance of witnesses and the production of relevant books and papers before the Board in any hearing relative to the application for or refusal, recall, suspension or revocation of a license or certificate. The court may compel obedience to its order by proceedings for contempt.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Record of proceedings.] § 17.05 The Department, at its expense, shall provide a stenographer to take down the testimony and preserve a record of all proceedings at the hearing of any case wherein a license or certificate may be revoked, suspended, placed on probationary status, or other disciplinary action taken with regard thereto. The notice of hearing, complaint and all other documents in the nature of pleadings and written motions filed in the proceedings, the transcript of testimony, the report of the Committee and the orders of the Department constitute the record of such proceedings. The Department shall furnish a transcript of such record to any person interested in such hearing upon payment therefor of one dollar per page for each original transcript and 50¢ per page for each carbon copy thereof ordered with the original; except that the charge for any part of such transcript ordered and paid for previous to the writing of the original record thereof shall be 50¢ per page for each carbon copy.

Amended by P.A. 77-2829, § 34, eff. Dec. 22, 1972; P.A. 78-255, § 61, eff. Oct. 1, 1973.

Report of findings and recommendations—Motion for Rehearing—Certificate of order of revocation, suspension, or other disciplinary action.] § 17.06. The Board shall present to the Director a written report of its findings and recommendations. A copy of such report shall be served upon the accused person, either personally or by registered or certified mail. Within 20 days after such service, the accused person may present to the Department his motion in writing for a rehearing, which written motion shall specify the particular ground therefor. If the accused person orders and pays for a transcript of the record as provided in Section 17.05, the time elapsing thereafter and before such transcript is ready for delivery to him shall not be counted as part of such 20 days.

At the expiration of the time allowed for filing a motion for rehearing the Director may take the action recommended by the Board. Upon the suspension, revocation, placement on probationary status, or the taking of any other disciplinary action, including the limiting of the scope, nature, or extent of one's practice, deemed proper by the department, with regard to the license, certificate or state hospital permit, the accused shall surrender his license or certificate to the Department, if ordered to do so by the Department, and upon his failure or refusal so to do, the Department may seize the same.

Each certificate of order of revocation, suspension, or other disciplinary action shall contain a brief, concise statement of the ground or grounds upon which the Department's action is based, as well as the specific terms and conditions of such action. This document shall be retained as a permanent record by the Board and the Director.

In those instances where an order of revocation,

suspension, or other disciplinary action has been rendered by virtue of a physician's physical illness, including, but not limited to deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill, or safety, the Department shall only permit this document, and the record of the hearing incident thereto, to be observed, inspected, viewed, or copied pursuant to court order.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Restoration of license or certificate.] § 17.07 At any time after the suspension, revocation, placing on probationary status, or taking disciplinary action with regard to any license or certificate, the Department may restore it to the accused person, or take any other action to reinstate the license to good standing, without examination, upon the written recommendation of the Board.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Review under Administrative Review Act—Venue.] § 17.08 All final administrative decisions of the Department are subject to judicial review pursuant to the provisions of the "Administrative Review Act", approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined as in Section 1 of the "Administrative Review Act".

Such proceedings for judicial review shall be commenced in the Circuit Court of the County in which the party applying for review resides; but if such party is not a resident of this State, the venue shall be in Sangamon County.

The Department shall not be required to certify any record to the Court or file any answer in Court or otherwise appear in any Court in a judicial review proceeding, unless there is filed in the Court with the complaint a receipt from the Department acknowledging payment of the costs of furnishing and certifying the record which costs shall be computed at the rate of 20 cents per page of such record. Exhibits shall be certified without cost. Failure on the part of the Plaintiff to file such receipt in Court shall be grounds for dismissal of the action. During the pendency and hearing of any and all judicial proceedings incident to such disciplinary action the sanctions imposed upon the accused by the Department shall remain in full force and effect.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Order of revocation or suspension as prima facie evidence.] § 17.09 An order of revocation, suspension, placing the license on probationary status, or other formal disciplinary action as the Department may deem proper, or a certified copy thereof, over the seal of the Department and purporting to be signed by the Director, is prima facie proof that:

1. Such signature is the genuine signature of the Director;
2. The Director is duly appointed and qualified; and
3. The Board and the members thereof are qualified.

Such proof may be rebutted.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Action and report of board—Reasons of disagreement by Director—Necessity for exercise of powers—Re-examination or re-hearing.] § 17.10.

None of the disciplinary functions, powers and duties enumerated in this Act shall be exercised by

the Department except upon the action and report in writing of the Board.

In all instances, under this Act, in which the Board has rendered a recommendation to the Director with respect to a particular physician, the Director shall, in the event that he disagrees with or takes action contrary to the recommendation of the Board, file with the Board and the Secretary of State his specific written reasons of disagreement with the Board. Such reasons shall be filed within 30 days of the occurrence of the Director's contrary position having been taken.

The action and report in writing of a majority of the Board designated is sufficient authority upon which the Director may act.

Whenever the Director is satisfied that substantial justice has not been done either in an examination, or in a formal disciplinary action, or refusal to restore a license or certificate, he may order a re-examination or re-hearing by the same or other examiners.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Confidentiality of information received at hearings.] § 17.11 In all hearings conducted under this Act, information received, pursuant to law, relating to any information acquired by a physician in attending any patient in a professional character, necessary to enable him professionally to serve such patient, shall be deemed strictly confidential and shall only be made available either as part of the record of such hearing or otherwise; (1) when such record is required, in its entirety, for purposes of judicial review pursuant to this Act; or (2) upon the express, written consent of the patient, or in the case of his death or disability, of his personal representative.

Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Liability for disciplinary action without reasonable basis in fact.] § 17.12 In the event that the Department's order of revocation, suspension, placing the licensee on probationary status, or other order of formal disciplinary action is without any reasonable basis in fact of any kind, then the State of Illinois shall be liable to the injured physician for those special damages he has suffered as a direct result of such order.

Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Report of violations—Immunity from liability—Assistance in medical competency examinations—Hearing officers.] § 17.13 Any physician licensed under this Act, the Illinois State Medical Society, the Illinois Osteopathic Association, the Chiropractic Association, or any component societies of any of these three groups, and any other person, may report to the Board any information such physician, association, society, or person may have which appears to show that a physician is or may be in violation of any of the provisions of Section 16 of the Medical Practice Act. Any such physician, association, society or person, participating in good faith in the making of a report, under this Act, shall have immunity from any liability, civil, criminal, or that otherwise might result by reason of such actions. For the purpose of any proceedings, civil or criminal, the good faith of any such physician, association, society or persons shall be presumed. The Board may request the Illinois State Medical Society, the Illinois Osteopathic Association, or the Illinois Chiropractic Association both to assist the Board in preparing for or conducting any medical competency examination as the Board may deem appropriate. The Board shall retain and

use such hearing officers as it deems necessary.

Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Amended by P.A. 80-965, § 1, eff. Sept. 22, 1977.

Punishment for doing certain acts without license.]. § 24. If any person holds himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings; or suggests, recommends or prescribes any form of treatment for the palliation, relief or cure of any physical or mental ailment of any person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever; or diagnosticates or attempts to diagnosticate, operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment, of another; or maintains an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment; or attaches the title Doctor, Physician, Surgeon, M.D. or any other word or abbreviation to his name, indicating that he is engaged in the treatment of human ailments as a business; and does not possess a valid license issued by the authority of this State to practice the treatment of human ailments in any manner, he shall be sentenced as provided in Section 35.1.

Amended by P.A. 77-2708, § 1, eff. Jan. 1, 1973.

Physician's Assistant Act

Section 1. The purpose and legislative intent of this Act is to encourage and promote the more effective utilization of the skills of physicians by enabling them to delegate certain health tasks to physician's assistants where such delegation is consistent with the health and welfare of the patient and is conducted at the direction of and under the responsible supervision of the physician.

Section 2. This Act shall be known and may be cited as the "Physician's Assistants Practice Act."

Section 3. "Physician's assistant" means any person not a physician who is certified to perform medical procedures under the supervision of persons licensed to practice under "The Medical Practice Act." A physician's assistant may perform such medical procedures within the specialty of the supervising physician, except that such physician shall exercise such direction, supervision and control over such physician's assistants as will assure that patients receiving medical care from a physician's assistant shall receive medical care of the highest quality. Physician's assistants shall be capable of performing a variety of tasks within the specialty of medical care under the supervision of a physician, although the physician's assistant does not possess the level of medical knowledge necessary to integrate and interpret findings. Physician's assistants cannot exercise independent judgment for purposes of diagnosis and treatment of patients. Nothing in this Act shall be construed as relieving any physician of the professional or legal responsibility for the care and treatment of persons attended by himself or by physician's assistants under his supervision. Physician's assistants shall have only those powers and rights set forth in this Act and the exercise of any powers beyond those set forth shall constitute a violation of this Act.

Section 4. No physician's assistant shall use the title of doctor or associate with his name any other term which would indicate to other persons that he is qualified to engage in the general practice of medicine. A physician's assistant shall not be allowed to bill patients or in any way to charge for

services. Nothing in this Act, however, shall be so construed as to prevent the employer of a physician's assistant from charging for services rendered by the physician's assistant. The physician shall file with the Department notice of employment and discharge of the physician's assistant at the time of said employment or discharge.

Section 5. No more than one physician's assistant shall be employed by a physician. Physician's assistants shall be employed only under the supervision of persons licensed to practice under "The Medical Practice Act" and engaged in private clinical practice, or in clinical practice in public health or other community health facilities.

Section 6. Each applicant for a physician's assistant certificate shall:

1. Make application for examination on forms prepared and furnished by the Department of Registration and Education.

2. Submit evidence under oath satisfactory to the Department that:

- (a) He is 21 years of age or over;
- (b) He is of good moral character;
- (c) He has the preliminary and professional education required by this Act;
- (d) He is free of contagious diseases.

3. Designate specifically the name, location, and kind of professional schools, colleges, or institutions attended and the courses which he has satisfactorily completed.

4. Pay to the Department of Registration and Education at the time of application, an examination fee of \$25. The fee for subsequent renewal of a certificate without lapse shall be \$15.

Section 7. Except as otherwise provided in this Act, the minimum standards of educational requirements prior to the taking of an examination shall consist of the following:

(a) Successful completion of a 4 year course of instruction in a high school, or its equivalent, as determined by the examining committee; and

(b) Successful completion of a specialized course for physician's assistants consisting of not less than 20 months instruction in any 2 year period; such course and the institution or school offering the same shall be approved by the examining committee provided for in this Act.

The examining committee shall have the power to waive the specialized training provided for in this Section, if the committee determines that any prior training and experience of the applicant is the equivalent of such specialized training.

Section 8. Registered nurses in the State of Illinois may take such examination without completing any additional courses of study and shall be issued a certificate upon the passage of such examination.

Section 9. Subject to the provisions of this Act, the Department of Registration and Education shall:

1. Promulgate rules approved by the examining committee setting forth standards to be met by a school or institution offering a course of training for physician's assistants prior to approval of such school or institution.

2. Promulgate rules approved by the examining committee setting forth uniform and reasonable standards of instruction, including but not limited to specific subjects taught, to be met prior to approval of such course of instruction for physician's assistants.

3. Determine the reputability and good standing of such schools or institutions and their course of in-

struction for physician's assistants by reference to compliance with such rules, provided that no school of physician's assistants that refuses admittance to applicants solely on account of race, color, sex, or creed shall be considered reputable and in good standing.

4. Prescribe rules for examining candidates for a certificate as physician's assistant.

5. All examinations provided for by this Act shall be conducted under rules and regulations prescribed by the Department of Registration and Education. Examinations shall be held at least 3 times a year at times and places to be determined by the Department.

No rule or regulation shall be adopted under this Act which allows a physician's assistant to perform any act, task or function primarily performed in the lawful practice of optometry under "The Illinois Optometric Practice Act," approved June 15, 1951, as amended.

Section 10. Upon the satisfactory completion of application and examination procedures and compliance with the applicable rules and regulations of the Department of Registration and Education, the Department shall issue a physician's assistant certificate to the qualifying applicant.

Section 11. The Medical Examining Committee of the Department of Registration and Education as provided in Section 60-a of "The Civil Administrative Code of Illinois," approved March 17, 1917, as amended, may revoke or withdraw the certificate issued under this Act upon any of the following grounds:

1. Conviction in this or another state of any crime which is a felony under the law of this State, or conviction of a felony in a federal court;

2. Gross malpractice resulting in permanent injury or death of a patient;

3. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

4. Habitual intemperance in the use of alcohol, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties.

5. Employment of fraud, deception or any unlawful means in applying for or securing a certificate as a physician's assistant;

6. Exceeding the authority delegated to him by his employing physician;

7. A violation of any provisions of this Act or of the rules and regulations formulated for its administration.

Section 12. No action of a disciplinary nature which is predicated on charges alleging unethical or unprofessional conduct of a person who practices as a physician's assistant and which can be reasonably expected to affect adversely that person's maintenance of his present, or his securing of future, employment as such a physician's assistant may be taken by the Department of Registration and Education, by any association, or by any person unless the physician's assistant against whom such charges are made is afforded the right to be represented by legal counsel of his choosing and to present any witness, whether an attorney or otherwise, to testify on matters relevant to such charges.

Section 13. Certificates may be revoked or suspended only in the manner provided by Section 60b through 60h inclusive of "The Civil Administrative Code of Illinois," approved March 7, 1917, as now or hereafter amended.

Section 14. All final administrative decisions of the Department of Registration and Education are subject to judicial review pursuant to the provisions of the "Administrative Review Act," approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined in Section 1 of the "Administrative Review Act."

Section 15. All certificates issued under this Act must be renewed every 2 years after their issuance and the examining committee may require a physician's assistant to submit to a mental or physical examination at any time felt necessary by the examining committee.

Section 16. No person shall use the title or perform the duties of "physician's assistant" unless he

is a qualified holder of a certificate as provided in this Act. A certified physician's assistant shall wear on his person a visible identification indicating that he is certified as a physician's assistant while acting in the course of his duties.

Section 17. The Medical Examining Committee of the Department of Registration and Education shall review the provisions of this Act to determine its effectiveness and accomplishments and shall solicit the cooperation and advice of such public and private agencies as the Committee may deem proper. The Committee shall report its findings and recommendations to the Governor and the General Assembly on January 1, 1980.

Section 18. This Act takes effect July 1, 1976.

Section 19. This Act is repealed on June 30, 1981.

DIVISION OF VOCATIONAL REHABILITATION

623 East Adams Street
Springfield, IL 62706
James S. Jeffers, *Director*

The Board of Vocational Rehabilitation is a statutory body, established to administer, through one division, the state program of vocational rehabilitation pursuant to the Federal Vocational Rehabilitation Act, as amended.

Medical Legal Information

(Prepared by ISMS Corporate Counsel)

The purpose of this article is to present to the Illinois medical community a general view of certain medical-legal principles and relationships which many physicians may encounter in the ordinary practice of their profession. Because this article is intended to provide information of a general nature only, specific problems should be discussed with one's individual attorney. While this presentation is not all-inclusive, it will afford an insight into the more common considerations. It should not be construed as presenting legal opinion, rather general considerations. Information is intended to be illustrative only and does not establish or imply a standard of care.

ISMS LEGAL SERVICES

The Illinois State Medical Society retains, on a continuing basis, a corporate counsel to whom the Society refers legal questions affecting the membership as a whole. ISMS also answers specific inquiries made by the component county medical societies when they are of general interest to the medical community. Although

the Illinois State Medical Society does not provide personal legal advice to individual members, the Society does believe the following information will help further each physician's awareness of certain basic legal principles and concepts vital to his practice.

THE PHYSICIAN-PATIENT RELATIONSHIP

Contractual Relationship

In most instances the physician-patient relationship is a voluntary, contractual one. Accordingly, physicians are required to accept only those patients they elect to treat. The professional services rendered on behalf of particular patients and the fees compensating the physician for those services are to be agreed between the physician and the patient. Whenever possible, the physician should discuss his fee with the patient in advance of treatment.

While a physician is free to determine who will be his patients, once the physician has undertaken the treatment of a particular patient, he is under a legal duty, subject to certain exceptions discussed below, to continue his attendance so long as the case requires attention.

A physician may legally terminate his attendance of a particular case in several ways:

1. The contract between the physician and the patient expressly limits the scope of treatment;

2. The patient may discharge the physician;
3. The relationship may end by mutual consent;
4. The physician may legally terminate his services if the patient breaks the contract by failing to observe the medical directives of the physician, or does not pay for the services rendered.

When the physician has a reasonable basis to terminate his care of the patient, he must provide the patient with sufficient, reasonable notice of his intention to withdraw so as to enable the patient to secure another physician.

HOSPITAL PATIENT RECORDS

Illinois law provides that hospitals in the state shall, upon the written demand of any discharged patient, permit that patient, the patient's physician or authorized attorney to examine and make copies of his medical records. With few exceptions, these disclosure provisions do *not* apply in the case of a psychiatrist-patient relationship. With respect to the physician's office records, the statute was amended in 1976 to provide that every physician shall, upon the demand of any patient who has been

This notice should be in writing and briefly explain to the patient the reason for the intended termination. If the patient returns to the attending physician, and has been unable to procure other medical assistance, the attending physician should *not* refuse continued treatment until a replacement has been secured. Upon request, the physician should make copies of his records of the care he rendered to the patient available to a new physician selected by the patient.

treated by him, permit the patient's attorney or physician who is currently treating him to examine and copy all medical records in connection with the treatment of the patient. Psychiatric records are excluded, except when ordered by a Court. The physician to whom the request is directed must respond within a reasonable time and shall be reimbursed by the patient or his representative for all reasonable costs resulting from examining or duplicating the physician's records.

NEGLIGENCE LIABILITY OF PHYSICIANS

Illinois law requires physicians and surgeons to exercise that degree of reasonable skill as is used in ordinary good practice. The failure to exercise such skill will result in liability if the patient is thereby injured.

In recent years, in part through the adoption of new laws, but primarily through court decisions, professional liability has been significantly expanded. A recent ruling of the Illinois Supreme Court, for example, extended liability in a certain circumstance for birth defects suffered by a child as a consequence of an injury its mother suffered eight years before the child was conceived. The Court reasoned that the defendant hospital and doctor should have known that the harm caused the mother could have resulted in injury to the child born many years later. This case establishes a "chain of accountability" which dramatically increases the doctor's liability and underscores the fact that the problems associated with medical malpractice continue to jeopardize the delivery of quality medical care.

The physician is liable for his own negligent acts and the negligent acts of all employees subject to his control or supervision while acting within the scope of their employment. In the case of a partnership, he also may be liable for the negligent acts of his partners.

Today there is simply no existing alternative to carrying adequate liability insurance. However, insurance coverage is not a panacea for expanded liability. Each physician must undertake affirmative efforts to reduce the risks associated with the rendering of health care services.

The American Medical Association published a pamphlet entitled "Professional Liability and the Physician." Twenty guidelines for preventing malpractice actions are set forth in that pamphlet:

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.

2. The physician must know and exercise his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician must keep records which clearly show what was done and when it was done and which demonstrate that the care given met fully the standards of good

care as practiced in the community or in similar communities. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.

5. A physician must avoid making any statement which constitutes, or might be construed as constituting, an admission of fault on his part. He should instruct employees to make no such statements.

6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.

7. The physician must refrain from over-optimistic prognoses.

8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.

9. The physician must unfailingly secure a consent, in writing, for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment.

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience, except after a complete explanation of the procedure and its risks and possible complications. He must also first obtain a signed consent from the patient and from the patient's spouse, if the patient is married. Eugenic sterilization should be performed

only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may be performed lawfully with the consent of the patient and preferably with the consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing a diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes and, in addition, should

ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

In addition to these general guidelines to good medical practice, the physician should keep current and be in compliance with hospital regulations and standards enforced by governmental agencies, the Joint Commission on Accreditation of Hospitals, and the bylaws of his hospital and its medical staff. The physician has the responsibility to maintain good records of his care of his patients, to recommend consultation when the advice of a specialist is indicated, and to keep his patients informed of the progress of their care. The physician, as a member of an organized hospital medical staff, also has the duty to participate in, and submit to, peer review for purposes of monitoring his professional credentials and performance and for evaluating the quality and appropriateness of the patient care he delivers.

ILLINOIS CONTROLLED SUBSTANCES ACT

Under the Illinois Controlled Substances Act, physicians who prescribe or dispense various controlled substances are required to register with the Illinois Department of Regis-

tration and Education. Categories of drugs under which registration is required are almost identical to those established by the Federal DEA.

LIMITS ON LIABILITY—SPECIAL SITUATIONS

Under the "Good Samaritan" amendment to the Medical Practice Act, physicians who, in good faith provide emergency care without fee to a person, shall not, as a result of acts or omissions, except willful or wanton misconduct, be liable for civil damages.

The Medical Practice Act further provides that any physician, serving on any medical utilization committee, medical review committee, or peer review committee shall

not be liable for civil damages as a result of his acts, or omissions, or decisions in connection with his duties on such committee, except those acts, omissions or decisions which involve willful or wanton misconduct. There are cases before the Illinois Courts challenging these grants of immunity and the ISMS is monitoring and cooperating in the defense of these lawsuits.

AUTOPSY

The *Illinois Revised Statutes* specifically detail the conditions under which a physician may perform an autopsy. Essentially, an autopsy may be performed provided:

1. The physician has a written authorization from the decedent to do so; or
2. The physician has a written authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right (a "surviving relative" means the spouse, an adult child, the parent, or an adult brother or sister of the decedent); or
3. The physician has a telegraphic or telephonic authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right. This last provision is conditioned, however, upon the requirement that the telegraphic or telephonic authorization is verified, in writing, by at least two persons who were present at the time and place the authorization was received.

Illinois law specifically provides that where two or more persons have equal right to determine the method for disposing of the body, the authorization of only one such person shall be necessary, unless, before the autopsy is

performed, any others having such equal right shall object in writing or, if not physically present in the community where the autopsy is to be performed, by telephonic or telegraphic communication to the physician by whom the autopsy is to be performed.

While authorization may be given to a physician or hospital administrator or his duly authorized representative, only a physician shall perform the autopsy. The authorized personnel of a hospital or other qualified personnel selected by a physician may assist a physician performing an autopsy.

The term "written authorization", provided for above, means any printed, typed or handwritten communication signed by the person granting the authorization.

It is important to emphasize that, in Illinois, the heirs and next of kin can bring an action for mutilation of the body of a decedent in those cases in which an autopsy is performed without authority or permission. In order to avoid the possibility of liability, autopsies should only be performed when ordered by the coroner or upon the appropriate written consent of the next of kin as specified above. (The coroner may order an autopsy directly against the wishes of the next of kin). Cooperation should be forthcoming in cases under the Coroner's jurisdiction.

DEATH

Since the controversy generated by the Karen Quinlan case (New Jersey); and the Joseph Saikowicz case (Massachusetts) much has been written about the physician's role in determining death. Some states, Kansas and California, for example, have adopted special legislation in an attempt to "regulate" the legal and medical definitions of

death and to provide so-called, "death with dignity" guarantees. To date, similar laws are not "on the books" in Illinois and, at present, the law of our state continues to provide that death occurs when in the judgment of the physician, there has been irreversible cessation of spontaneous vital functions (heart beat and respiration).

CONSENT OF MINORS TO MEDICAL TREATMENT

1. Situations Where Consent Need Not Be Obtained For Treatment of a Minor: Whenever a hospital or a physician renders emergency treatment or first aid (or a licensed dentist renders emergency dental treatment) to a minor, consent of the minor's parent or legal guardian need not be obtained if, in the sole opinion of the physician, dentist or hospital, the obtaining of consent is not reasonably feasible under the circumstances without causing a delay which could adversely affect the condition of such minor's health.

2. Parental Consent for Treatment of a Minor Child When Parent is Also a Minor: Illinois law provides that any parent, including a parent who is a minor, may give his or her consent to the performance upon his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery or a dental procedure by a licensed dentist. The consent of such parent is not voidable because of his or her minority, and Illinois law specifically provides that this parent, who is a minor, is deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age.

The consent to the performance of a medical or surgical procedure, by a physician licensed to practice medicine and surgery, which is executed by a married person who is a minor or by a pregnant woman who is a minor, is not voidable because of such minority and Illinois law further provides that for such purpose, such married person, who is a minor, or such pregnant woman, who is a minor, is deemed to have the same legal capacity to act and has the same powers and obligations as has a person who has attained majority (age 18 or older).

3. Birth Control Services for Minors: Birth control services and information may be rendered by doctors licensed in Illinois to practice medicine in all of its branches to any minor who meets any of the following criteria: is married; is a parent; is pregnant; has the consent of parent or legal guardian; as to whom the failure to provide such services would create a serious health hazard; or is referred for such services by a physician, clergyman or a planned parenthood agency.

4. Venereal Disease and Drug Use—Consent to Treatment By Minor: Illinois law specifically provides that a minor, 12 years of age or older, who may have come into contact with any venereal disease or who is suffering from the use of depressant or stimulant drugs or narcotic drugs (as defined in Controlled Substances Acts), may give his or her own binding consent, which is not later voidable, to the furnishing of medical care or counselling related to the diagnosis or treatment of such disease or addiction. Each incident of venereal disease shall be reported to the State Department of Public Health or the local board of health in accordance with existing regulations. Illinois law specifically states that the consent of the parent, parents, or guardian of such minor, receiving such treatment or counselling, shall not be necessary to authorize the care or counselling which is related to the diagnosis or treatment of such disease or drug or narcotic use.

Any physician who provides diagnosis or treatment to a minor patient who has come into contact with any venereal disease or suffers from the use of any drug or narcotic, referred to above, may, but shall not be obligated to, inform the parent, parents or legal guardian of any such minor as to the treatment given or needed.

UNEMPLOYMENT COMPENSATION

The Illinois Unemployment Compensation law has been expanded so that it now includes coverage by physicians who employ only one person. This liability was discussed at some length in the "Practice Management" section of the July, 1973, issue of the *Illinois Medical*

Journal. If physicians have specific questions regarding the applicability of unemployment compensation to their employees, they should consult the Illinois Department of Labor, Division of Unemployment Compensation, or their attorney.

BLOOD LABELING

The Illinois Blood Labeling Act contains three requirements of particular importance to the medical profession:

1. No person may administer blood by transfusion in Illinois unless the container of such blood is labeled in conformity with regulations developed and specified by the Illinois Department of Public Health;

2. When blood is administered by transfusion in Illinois, the identification number of the unit of blood must be recorded in the patient's medical record and the label on the container of blood may not be removed before or during the administration of that blood by transfusion;

3. As of July 1, 1973, no blood (which has been initially acquired by purchase) may be administered by transfusion in Illinois unless:

- The physician in charge of the treatment of the patient to whom the blood is to be administered has directed that such purchased blood be administered to that patient; and
- The physician in charge of the treatment of the patient has specified in the patient's medical record his reason for such action.

IMMUNIZATION

In 1972, legislation was passed to eliminate the requirement of smallpox immunization and to add rubella to the list of diseases against which there must be immunization.

The 1973 session of the Illinois General Assembly, however, eliminated a listing of specific diseases against which

there must be immunization and transferred responsibility for determination of these to the Illinois Department of Public Health. Thus, the director will promulgate regulations, which may change from time to time, as to those diseases against which children will be immunized. This affects the School Code and the Communicable Disease Act.

MEDICAL CORPORATIONS

Until 1963, when the Illinois General Assembly passed the Medical Corporation Act, physicians were not able to avail themselves of the legal advantages of doing business as a corporation. A primary reason for forbidding the use of the corporate form for doctors was that the personal assets of the officers, directors and stockholders are generally beyond the reach of creditors, including persons who acquire a legal claim against the corporation after suffering injury resulting from the actions of the agents of the corporation. Because the public wished to insure itself of the best medical care, the law would not permit doctors to insulate themselves from personal malpractice liability by the use of a "corporate shield." However, the Corporation can be sued as the employer and the individual doctor-employee can also be sued.

The corporate form does, however, present certain advantages, particularly in the area of taxation. There has never been a compelling reason to deny these benefits to doctors and other professionals.

Under the Illinois law, all the shareholders, officers and directors of a medical corporation must be licensed physicians. In the case of a professional services corporation also authorized under current Illinois law, the secretary of the corporation need not be a physician.

The corporation must register with the Illinois Department of Registration and Education under whose auspices it is permitted to operate, in addition to the requirements of filing with the office of the Secretary of State. This law explicitly denies physicians working within a corporation the right to insulate their personal assets from malpractice liability.

Tax consequences are the primary factors in determining the wisdom of incorporation. In an article written for the November, 1970, issue of the *Illinois Bar Journal* Linscott R. Hanson summarized the advantages of incorporation. Among the major advantages listed were:

1. Deductability by employees of a portion of their sick pay.
2. Deductability as a corporate business expense of the full cost of employee accident and health insurance.
3. Deductability as a corporate business expense of medical payments in excess of insurance.

MDs EXCLUDED FROM 'CERTIFICATE OF NEED' CONTROLS

Plans to build, expand, move or sell a hospital, nursing home or surgicenter require approval of the State Health Facilities Planning Board.

A provision in the original legislation which would have brought physicians' offices and clinics under "certificate of need" regulation was withdrawn because of vigorous ISMS opposition. At the federal level, renewed efforts are underway to bring all outpatient facilities, including the doctor's office, under the provisions of the law.

This law covers construction or modification plans involving an expenditure of more than \$150,000, or a substantial change in services or bed capacity.

4. Lower corporate tax rates for funds to be re-invested in the business.

5. Relatively easy adjustment of ownership percentages.

6. Avoidance of many probate problems upon the death of a practitioner and the avoidance of having to create a whole new business as when a partner dies.

7. Liability limitation, other than for malpractice, to the investment in the corporation thus reducing investors' risks.

8. Miscellaneous pension and profit-sharing tax advantages.

There are also some disadvantages or requirements associated with incorporation, as follows:

1. Since a corporation is a separate legal entity, there are certain minimal requirements necessary "to give life and credibility" to the corporate form (record keeping; governance; etc.). Simply declaring yourself a corporation is not enough; the law requires that you operate in accordance with laws governing corporate organizations. Occasionally problems can arise and the physician may incur costs of legal defense in his dealings with the Internal Revenue Service and other governmental bodies as when they challenge his activities carried out in the name of the corporation.

2. Corporations produce other unique costs as well, including additional social security taxes; corporate franchise taxes; capital stock and personal property taxes; increased state income taxes; state licensing fees; and other taxes and fees.

3. Corporations usually generate higher administrative and legal costs.

4. Corporations are subjected to many state and federal laws and regulations.

Certainly each practitioner, physician and partnership should consider the merits of incorporating. The purpose here has been to give a brief explanation so that each interested physician can receive a general over-view of his options. A tax specialist should, of course, be consulted to review the particulars of each business situation.

Under Public Law 93-641, local Health Services Agencies are to hold public hearings on all applications for construction or expansion of facilities before submitting a recommendation to the state Health Planning Board for final action.

The state agency is required to study: (1) area size; (2) population and growth potential; (3) number of existing and planned facilities offering similar services; (4) utilization of existing facilities; (5) availability of alternative facilities and services; and, (6) availability of necessary personnel.

Undoubtedly, the role of health planning agencies will expand and the physician will feel the effects and influ-

ence of regulations promulgated by these organizations. While the private practice of medicine is as yet relatively "free" of the jurisdiction of these agencies, the decisions of the Board are already reaching out to limit the purchase of new equipment and the development of new services by hospitals and other institutions in which the

doctor performs many of his professional services. It is reasonable to expect that with the current government emphases on cost containment in health care, the physician's practice can and will be affected. Therefore, it is in each physician's best interest to monitor these developments closely in the months and years ahead.

CURRENT DEVELOPMENTS IN HEALTH LAW

The practice of medicine has been subjected to increasing regulation at all levels of government. At the federal level, in addition to HEW, many other agencies are making administrative decisions and promulgating rules and regulations which impact upon the physician and his practice environment. For example, the Federal Trade Commission is investigating the collective activities of doctors which may have had an anti-competitive or anti-consumer result. The pressure is mounting in favor of liberal policies permitting advertising of medical services and for expanding the role of para-professional groups in the delivery of health care.

At the state and local levels, generic drug substitution laws, statutes authorizing the administration of Laetrile and other substances and other consumer-oriented legislation has been widely adopted.

In response to these initiatives, the Illinois State Medical Society, by action of its Board of Trustees, developed

a program of legal assistance for its members. This Legal Assistance Plan has been approved by the Internal Revenue Service so as to avoid any jeopardy to the tax exempt status of the Society. The Plan will provide legal assistance, funded by the Society, in limited circumstances when the legal issue at stake is of such universal and important consequence as to affect the rights, not only of the individual physician who is a party to the litigation or administrative proceedings, but to all members of organized medicine. The Executive Committee of the Board acts as a review body to receive written requests for legal assistance and to evaluate each request on its merits. To date, the Society has approved assistance in several cases and has authorized legal counsel to file friend-of-the-court briefs in two lawsuits in which legal issues of considerable significance to practicing physicians were raised.

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'78 Legislative Session Marked By Firsts

Each year, the Illinois General Assembly sets goals for itself which are designed to keep the legislature functioning smoothly. Some of those goals become impossible to fulfill, due to the amount and variety of legislation introduced. This year, however, the legislature outdid itself in keeping to its own deadlines, thereby accomplishing several remarkable firsts.

1. The legislature adjourned on time.
2. Most committees were able to keep to their own schedules and to accomplish everything they were supposed to in the time they were supposed to do it.
3. The even-numbered year session of the legislature is supposed to be limited to budgetary and revenue matters. With only a few exceptions that is precisely what the legislature limited itself to.

One of the most "notable exceptions" to this statement was the extensive debate on the Equal Rights Amendment. All other items were put on

a back burner, pending the outcome of the ERA vote. As has been reported in every newspaper in the state, ERA was defeated, but only then was the legislature able to move rapidly through the remainder of its business.

A second "notable exception" was a proposal in which ISMS was vitally interested—the revision of the Mental Health Code. This package of bills resulted from almost four years of research, public hearings, and work by the Governor's Commission on the Revision of the Mental Health Code, established by Governor Walker. The bills were introduced in 1977 and were again the subject of weeks of additional study, modification, and hearing, which finally culminated in their passage on June 30, 1978.

The legislature is now adjourned until after the November elections, when they will reconvene to consider any Thompson vetoes.

The following is a list of major ISMS legislation and its status.

BILL #	SPONSOR	DESCRIPTION	STATUS AS OF 9-15-78
HB 2339	Tipsword Berman	Hospital Rate Review Act (See SB 1060)	Senate—Second Reading
HB 2418	House Com. on Revenue	Abolishes personal property tax; replaces revenues lost with new taxes on corporations, partnerships, associations, estates & trusts, etc.	In Senate Rules Committee
HB 2506	House Human Resources Com.	Reinstates permit physicians in mental health institutions.	Vetoed by the Governor on 7/3/78
HB 2625	Ebbesen Grotberg	Permits M.D.'s to use cannabis to treat glaucoma or side effects of chemotherapy.	Signed 9-12-78
HB 2794	Yourell	Abolishes County Hospital Governing Commission—gives functions, powers & duties to University of Illinois.	House—Interim Study
HB 2878	House Human Resources Com.	Amends Comprehensive Health Planning Act.	Defeated in the House
HB 2883	House Human Resources Com.	Certificate of Need Legislation	House—Interim Study
HB 3059	House Human Resources Com.	Ambulance Service Act to license & regulate ambulances.	Defeated in House
HB 3097	Winchester Sangmeister	Amends Acts relating to the establishment & maintenance of health departments & public health districts.	Amendatory Veto 9-15-78
HB 3125	E. Barnes	Reduces line items in Public Aid budget—including medical assistance.	Held in House Committee
HB 3157	Redmond Leonard	Adds to list of grounds for revocation of medical vendor licenses by Dept. of R & E for violations under medical assistance program.	Amendatory Veto 9-11-78

BILL #	SPONSOR	DESCRIPTION	STATUS AS OF 9-15-78
HB 3158	Redmond	Creates Public Aid Fraud Investigation Unit within Dept. of Law Enforcement.	Defeated in the House
HB 3160	Redmond Lane	Requires Public Aid recipient social security number be listed on vouchers.	Defeated on Senate Floor
HB 3161	Redmond Leonard	Requires IDPA to report annually to General Assembly on proposed rate structure for medical vendors.	Amendatory Veto 8-18-78
HB 3163	Redmond	Requires all departments to act on any application within 90 days.	House—Interim Study
HB 3227	Stiehl Schaffer	Allows use of physician license fee for expenses of Medical Examining Committee and to monitor CME.	Signed 6-30-78
HB 3296	Campbell Newhouse	Creates Long Term Care Peer Protection Act.	Signed 8-2-78
HB 3399	Polk	Amends Blood Bank Act removing requirement that blood bank director must be certified by American Board of Pathology.	In House Rules Committee
SB 250	Netsch Sandquist	Creates new Mental Health Code.	Signed 9-5-78
SB 252	Nimrod Willer	Provides for guardian for adults who are developmentally disabled or mentally ill.	Signed 9-5-78
SB 253	Daley Beatty	Creates Human Rights Authority Act to "safeguard rights of persons receiving mental health or developmental disability services."	Signed 9-5-78
SB 255	Demuzio Mugalian	Provides all records of persons receiving mental health and developmental services are confidential and may be disclosed only as provided in this Act.	Amendatory Veto 9-5-78
SB 1060	Berman Tipsword	Hospital Rate Review Act (comparable to HB 2339).	Signed 8-7-78
SB 1616	Berning Deuster	Requires consent of parent or guardian of persons under 18 prior to administration of Laetrile.	Tabled.
SB 1760	Newhouse Yourell	Increases size of Cook County Hospital Governing Commission.	Defeated on House Floor
SB 1761	Newhouse Levin	Allows Cook County Hospital Governing Commission to be reimbursed for services to inmates of Cook County jail.	Passed Senate— In House Rules Committee
SB 1800	Lane	Requires Public Aid recipient social security number be listed on vouchers (comparable to HB 3160).	Defeated in the Senate
SB 1822	Leonard Chapman	Requires IDPA to file annual report with General Assembly re. provisions and use of medical services and proposed rate structures for medical providers (comparable to HB 3161).	Tabled in House Committee
SB 1827	Graham Friedland	Establishes the Pre-Hospital Emergency Services Act.	Signed 7-27-78
SB 1850	D'Arco Kucharski	Reinstates psychiatric care under State Employee Group Insurance Act.	Vetoed by the Governor 8-23-78

IMPAC

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

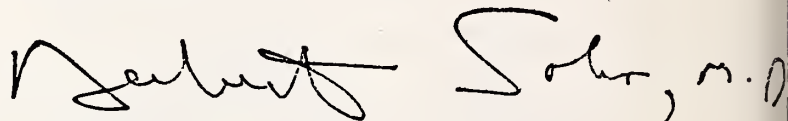
Dear Doctor:

I'm sure by now that most of you are aware of what IMPAC is, what it does, and how it works. I trust that this page has been helpful in broadening your understanding of IMPAC, as many of you have joined.

However, it is extremely disturbing that all of you and your spouses aren't members of organized medicine's most active political arm. The IMPAC Council believes that those of you who don't belong must want further information regarding IMPAC. To provide more information we have developed the brochure which immediately follows this letter. Once you've read it, we're sure you'll join those of us who fully comprehend the effects of politics on medicine.

I am concluding this letter with your IMPAC membership application. Please fill it out now. Then read the brochure. If you agree that IMPAC can help open important political doors, mail the application with your membership today. Join the thousands of physicians and their spouses who contribute to medicine's future.

Sincerely, ¹⁸



Herbert Sohn, M.D.
Chairman

IMPAC/AMPAC Membership

(check one)

☐ Sustaining, \$99 ☐ Family, \$45 ☐ Regular, \$25 ☐ Auxiliary, \$20

Return to:

IMPAC, 55 E. Monroe Street, Suite 3510, Chicago, Illinois 60630

NAME _____ PHONE _____

ADDRESS _____ CITY _____ ZIP _____

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

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IMPAC

The Who of IMPAC

You are IMPAC, you and your spouse and other physicians, and their spouses from across Illinois.

The What of IMPAC

IMPAC (The Illinois Medical Political Action Committee) is the political voice of medicine in Illinois.

The Why of IMPAC

IMPAC exists to give the Illinois physician an effective organized means of political action by using its funds to:

1. Educate and stimulate the voting public;
2. Support specific candidates, by direct candidate support and through organization of candidate support committees.

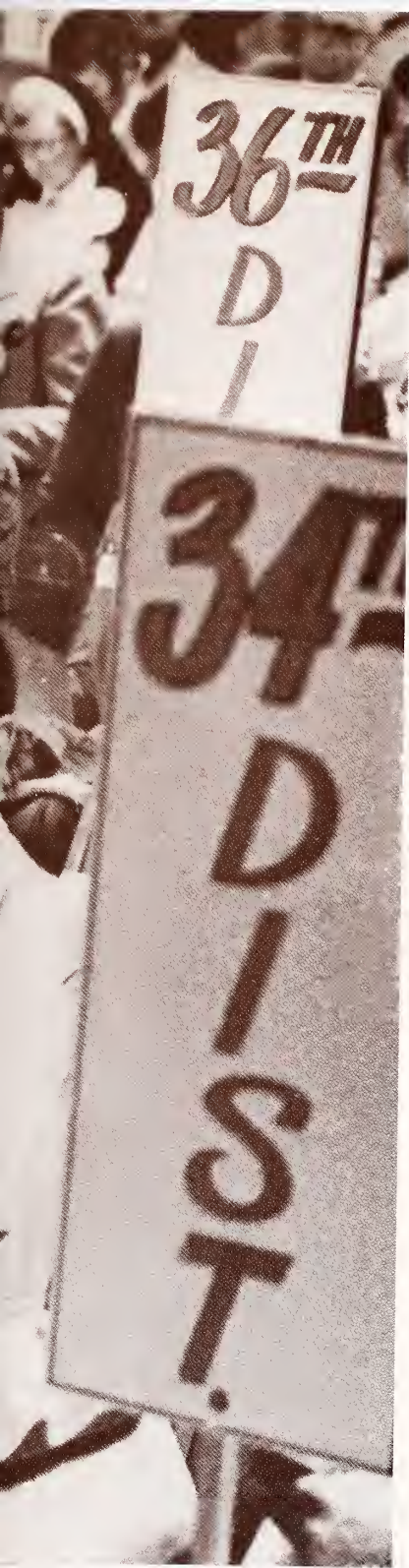
IMPAC activities are directed by a 30-member Council, one third of which is elected annually at the IMPAC annual meeting. Decisions are based on local physician activity on behalf of and interest in specific candidates. An additional important concern in the decision making process is a realistic appraisal of the district and the candidate.

The How of IMPAC

IMPAC functions independently of all medical organizations and societies—national, state and local—as required by Federal law. All political activities are supported by voluntary contributions from individual physician members.

IMPAC is not bound by either Democrat or Republican labels. IMPAC's goal is to elect the best possible candidates to all offices regardless of party. IMPAC's record is one of support for the man and his platform and philosophy, not his party.





Why Join IMPAC?

IMPAC gets our foot in their door.

The future of medicine will be determined in the political arena. Each session of the Illinois General Assembly considers hundreds of medically-related bills. On the national level, more than 2,500 medically-related bills are proposed each session.

The most effective way we can be sure that medicine's views are heard on these complex issues is to be involved in the political process which elects the legislators who will debate them.

To be truly effective, IMPAC needs the active support and participation of all physicians . . . We don't buy votes. Your contributions to IMPAC are used to support candidates from both parties who will give us a chance to tell them the facts.

IMPAC gets you involved.

Helping medicine tell its story is much more than a monetary proposition. IMPAC offers you know-how in evaluating a candidate and a campaign, raising money for a candidate, and in general provides the most effective means for physicians and their spouses to participate in the political and governmental process—areas which will ultimately determine how the practice of medicine will be structured in the future.

Local physicians know their own legislators best and IMPAC relies heavily on their comments and ideas in making decisions about candidate support.

IMPAC gets YOU involved!

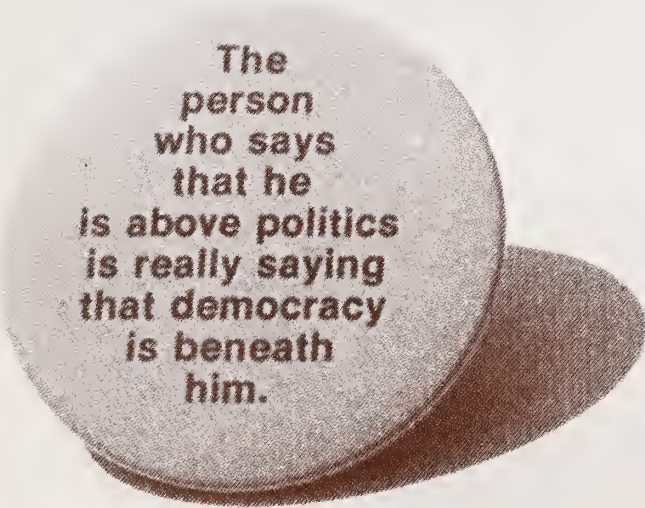
You Need IMPAC and IMPAC Needs You

IMPAC is working hard in bipartisan political activity to insure that medicine will be heard. IMPAC lets our representatives know that physicians and their spouses are interested in the laws that affect the practice of medicine and the health of the people of Illinois.

You Need IMPAC!

But success in the area of politics can only be accomplished through the concerted contributions and involvement of all the physicians and their spouses. An organized chorus of opinion commands attention whereas an individual voice often gets unheard.

Yes, IMPAC needs you!



The
person
who says
that he
is above politics
is really saying
that democracy
is beneath
him.

The Illinois Medical Political Action Committee
55 E. Monroe St., Suite 3510, Chicago, Illinois 60603
(312) 782-1963

Convention Handbook



INTERIM MEETING '78

Wagon Wheel Lodge
Rockton, Illinois

Members of the House of Delegates

Delegates and Alternate Delegates to the Illinois State Medical Society

Officers of County Medical Societies

ISMS Delegation to the American Medical Association

AMA Delegation Report

Schedule of Meetings

Committees of the House of Delegates

Resolutions

for October, 1978

Members of the 1978

Interim Meeting

House of Delegates

OFFICERS

President	David S. Fox
President-Elect	P. John Seward
1st Vice President	Herschel Browns
2nd Vice President	G. W. Giebelhausen
Secretary-Treasurer	Audley F. Connor, Jr.
Speaker of the House	Cyril C. Wiggishoff
Vice Speaker	Robert P. Johnson

TRUSTEES

First District	John J. Ring	1980	Fourth District	Joseph Sherrick	1980
Second District	Allan L. Goslin	1980	Fifth District	Fred Z. White	1979
Third District	Alfred Clementi	1979	Sixth District	Paul F. Mahon	1979
	Raymond DesRosiers	1980	Seventh District	Robert R. Hartman	1981
	Robert T. Fox	1979	Eighth District	Alfred J. Kiessel	1979
	Jere E. Freidheim	1979	Ninth District	James Laidlaw	1979
	Morris T. Friedell	1981	Tenth District	Warren D. Tuttle	1981
	Henrietta Herbolzheimer	1981	Eleventh District	Julian W. Buser	1981
	Lawrence L. Hirsch	1981	Twelfth District	Kenneth A. Hurst	1980
	Harold J. Lasky	1980	Trustee-at-Large	Joseph Perez	1980
	Richard N. Rovner	1980		George T. Wilkins, Jr.	

Past Presidents

J. Ernest Breed	1971	Fredric D. Lake	1975
Edward W. Cannady	1970	Willis I. Lewis	1954
Everett P. Coleman	1945-46	Burtis E. Montgomery	1966
Newton DuPuy	1968	Edward A. Piszczek	1965
Harlan English	1964	Caesar Portes	1967
Edwin S. Hamilton	1962	Willard C. Scrivner	1974
H. Close Hesseltine	1961	Joseph H. Skom	1977
J. M. Ingalls	1976	Leo P. A. Sweeney	1953
C. J. Jannings, III	1972	Philip G. Thomsen	1969
Frank J. Jirka, Jr.	1973	George T. Wilkins, Jr.	1978

Delegates to AMA

Herschel Browns	Jack L. Gibbs	John J. Ring
Allison Burdick, Jr.	Theodore Grevas	Joseph H. Skom
Howard C. Burkhead	Lawrence L. Hirsch	Fred A. Tworoger
David S. Fox	Morgan M. Meyer	Charles K. Wells
	Joseph R. O'Donnell	

Past Trustees or Councilors

Earl H. Blair	Third District	William M. Lees	Third District
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Herbert Dexheimer	Tenth District	Mather Pfeiffenberger	Sixth District
Alfred Faber	Third District	Ralph N. Redmond	Second District
George E. Giffin	Second District	George Shropshire	Third District
Arthur F. Goodyear	Seventh District	Darrell H. Trumpe	Fifth District
Lee N. Hamm	Fifth District	Frederick E. Weiss	Third District
Eugene Hoban	Third District	Charles K. Wells	Ninth District
Ross Hutchison	Eleventh District	Herman Wing	Third District
Eugene P. Johnson	Eighth District	Warren Young	Third District
Ted LeBoy	Third District	Paul P. Youngberg	Fourth District

Delegates and Alternate Delegates to the Illinois State Medical Society

DOWNSTATE DELEGATES

County	Delegates	Alternate	County	Delegates	Alternate
ADAMS	Walter Stevenson, III	Marvin Grote	MACON (2)	D. Statzer	C. O. Stanley
ALEXANDER	Charles L. Yarbrough	Gemo Y. Wong		J. Schrodt	
BOND	M. K. Kaufman	Boyd McCracken	MACOUPIN	Robert G. England	J. K. Villigas
BOONE	M. Mijanovich	Earl Davis	MADISON (2)	E. K. DuVivier	Edward Ragsdale
BUREAU	Louis D. Tarsinos	Louis Lukancic		Melvin Freedman	Robert Hamilton
CARROLL	L. B. Hussey	C. G. Piper	MARION	E. F. Stephens, III	W. P. Plassman
CASS-BROWN			MASON	Jack Means	
CHAMPAIGN (3)	Harold Kolb	Richard C. Adams	MASSAC		
	Richard Helfrich	Michael Russo	MCDONOUGH	Samuel M. Gines	John S. Goncher
	Frank Kresca	Harlan Failor	McHENRY	August M. Rossetti	William Larsen
CHRISTIAN	M. T. Salaymeh		McLEAN (2)	Loren Boon	Wil Thielemann
CLARK	George T. Mitchell	Eugene P. Johnson		Robert Reardon	Robert Knight
CLAY			MENARD		
CLINTON	Wilson L. DuComb	James A. Kirby	MERCER	Monty P. McClellan	James W. Hastings
COLES-			MONROE	E. F. Maglasang	
CUMBERLAND	Mack W. Hollowell	Joseph Mallory	MONTGOMERY	Lee Johnson	
CRAWFORD	Charles Salesman	T. P. Sloan	MORGAN-SCOTT	Frank Norbury	Thomas Wilson
DEKALB	John W. Ovitz, Jr.		MOULTRIE		
DEWITT	S. Kolandaivelu	Robert E. Myers	OGLE	Don E. Hinderliter	Vincent Traina
DOUGLAS	Humberto Mondul	Robert Arrol	PEORIA (4)	Ernest F. Adams	John J. Taraska
DUPAGE (8)	Morgan M. Meyer	John V. Ryan		Gregory Spano	Dennis Garwacki
	James P. Campbell	Joseph P. McKay		Wilbert Newcomer	Ronald Kowalski
	William C. Perkins	Neil S. Agruss		Gene O. Hoerr	Thomas Cusack
	William B. Frymark	Orren D. Baab	PERRY	C. E. Cawvey	B. A. Kinsman
	Joseph R. O'Donnell	Robert D. Dooley	PIATT	Wm. E. Mundt	George G. Green
	Raymond A. Dieter	Vernon H. Bartley	PIKE	Carlos B. Lara	Thomas C. Bunting
	Thomas W. Stach	Ralph Ryan	PULASKI	A. L. Robinson	
	Ronald M. Severino	Harold G. Bicek	RANDOLPH	O. W. Pflasterer	Stephen M. Platt
EDGAR	J. M. Ingalls	J. R. Shackelford	RICHLAND	Charles A. DeKovessey	Michael E. Murray
EDWARDS	Andrew Krajec	Paul Nierenberg	ROCK ISLAND (3)	James F. Duesman	Manuel O. Guerrero
EFFINGHAM	Robert Farmer			Donald D. Tomlin	Richard D. Retz
FAYETTE	D. H. Rames			Richard Arnell	Phillip T. Siegert
FORD	Somchai Supawanich	Edson Etherton	ST. CLAIR (3)	H. Frank Holman	Terrence G. Klingele
FRANKLIN	James Durham			Thomas P. Meirink	Michael G. Murphy
FULTON	Jack Gibbs	Rod Maguire		Mays C. Maxwell	Charles C. Weiland
GALLATIN	John E. Doyle		SALINE-POPE-		
GREENE	James C. Reid	Jose Parcon	HARDIN	A. Z. Goldstein	C. E. Seten
HANCOCK	Charles F. Eddingfield	Muhammed Hafeez	SANGAMON (4)	Twofig M. Arjmand	Jess Diamond
HENDERSON	Silvino C. Lindo			Edward G. Ference	David B. Lewis
HENRY-STARK	Richard M. Terry	William D. Larson		Robert L. Prentice	Michael Snyder
IROQUOIS	R. K. Swedlund	J. E. Dailey		Gerald T. Riordan	Richard Suhs
JACKSON	Paul P. Lorenz	Eli L. Borkon	SCHUYLER	Henry C. Zingher	Robert E. Cox
JASPER			SHELBY	Theodore Little	Edwin J. Siroy
JEFFERSON-			STEPHENSON	William H. Isham	F. H. Descourouez
HAMILTON	James R. Heersma	H. Goff Thompson	TAZEWELL	Roger E. Neumann	Robert M. Wright
JERSEY-			UNION	Robert Rader	Wm. Whiting
CALHOUN	Bernard Baalman	Herman Wuestenfeld	VERMILION	W. F. Hensold	Grover W. Seitzinger
Jo DAVIESS	Lyle A. Rachuy		WABASH	R. L. Fuller	Wm. Walling
KANE (4)	A. Beaumont Johnson	James C. Pritchard	WARREN	K. E. Ambrose	J. Marshall
	Wayne Leimbach	Peter Starrett	WASHINGTON	J. L. Beguelin	
	James A. McDonald	William Sheehy	WAYNE	C. J. Jannings, III	C. Loftin
	George Shimkus		WHITE	Phillip Boren	
KANKAKEE	Donald Parkhurst	Richard Stoval	WHITESIDE	John Hubbard	Clarence Mueller
KENDALL	Walter H. Brill		WILL-GRUNDY (3)	Merle L. Otto	Kenneth M. Uznanski
KNOX	Jerry Ramunis	Richard M. Flacco		Guy A. Pandola	John D. Walter
LAKE (5)	Arthur A. Woloshin	Gerald M. Goshgarian		Robert J. Becker	Albert W. Ray, Jr.
	David S. Helberg	Richard K. Hawkins	WILLIAMSON	Herbert V. Fine	Renato Katubig
	Earl V. Klaren	Homer Goldstein	WINNEBAGO (5)	Robert Behmer	R. Glenn Smith
	Eugene Pitts	Silverio Aguilar		George C. Green	H. Clifford Carlson, Jr.
	Hugh Falls	James Creath		Eugene T. Leonard	Raymond Hoffman
LA SALLE	E. J. Fesco	Richard Schmidt		F. H. Riordan, III	Ronald Ramstedt
LAWRENCE	R. C. Kirkwood	Larry Herron		Richard C. Webb	
LEE	Donald Edwards	Kyu Jin Cho	WOODFORD	Ronald Meyers	Robert Lykkebak
LIVINGSTON	Karl T. Deterding	John C. Purnell	STUDENTS	David Aizuss	Jason Chao
LOGAN	Glen E. Tomlinson		HOUSESTAFF	James DeBord	Anthony Savino

Cook County Delegates

<i>Delegates</i>	<i>Alternate Delegates</i>	<i>Delegates</i>	<i>Alternate Delegates</i>
Aaronson, Donald	Ahstrom, James, Jr.	Meisenheimer, Martin P.	Nainis, William S.
Ackley, William O.	Ashley, William F.	Moles, Joseph B.	Nikurs, Lydia
Andelman, Samuel L.	Banich, Francis E.	Murray, Meredith B.	Olivar, Adriano S.
Andersen, James H.	Banuchi, Fedor F.	Nemecsek, Raymond W.	Olivieri, Ernest P.
Blankshain, Richard	Barber, Frederick	Neskodny, J. F.	O'Sullivan, Donal D.
Bogen, Gilbert	Bartolome, Juanito	Norberg, Clarence A.	Pemintuan, Rodolfo, L.
Brislen, Andrew J.	Beck, Charles A.	O'Brien, James C.	Panayotou, Irene
Brown, Finley W. Jr.	Berg, Max	Odiaga-Garcia, Ignacio	Pantone, Anton M.
Budrys, Stanley	Bild, Sidney	O'Donnell, John W.	Paull, Murry M.
Burkhead, Howard C.	Borden, Nicholas J.	Okner, Henry B.	Pedroso, Aldo F.
Chamberlain, Danford O.	Borelli, Nelson	Palumbo, Carl F.	Perritt, Richard A.
Ciskoski, Ronald J.	Branovacki, Eugene	Patlak, Erwin M.	Pill, Michael P.
Costanzo, Vincent A.	Burdick, Allison L., Jr.	Peterson, Arthur R.	Pleotis, Peter
Cross, Roland R.	Burdick, Allison L., Sr.	Petty, David T.	Poma, Pedro A.
Czeisler, Tibor	Burke, Edward A.	Quinlan, Donald	Prombo, Marjorie P.
DeYoung, Willard	Cermak, Miles	Razim, Edward A.	Pruc, Jeremias N.
Falloon, Edwin L.	Chaljub, Najib	Reeder, Clifton L.	Rebendel, Marek B.
Filipowicz, Roman I.	Christensen, Eldis M.	Rice, C. Malcolm Jr.	Rodriguez, Ignacio
Fischer, Arthur	Constantaras, Alexander	Romanus, Raymond J.	Rogin, Alan
Fish, William	De La Mata, Augustin	Rothstein, David A.	Rosenzweig, Oscar
FitzGibbons, James P.	De Rose, William F.	Sarley, Vincent C.	Rowlette, Raymond S.
Flanagan, C. Larkin	De Trana, Frank A.	Saxena, Virendra S.	Roy, Shirley
Frankel, Jerome J.	Diaz, Alfonso	Schimmel, Samuel J.	Ruane, Michael
Freda, Vincent C.	Diffenbaugh, Willis G.	Sedlak, Frank	Saltiel, Isaac
Fredrick, Earl Jr.	Farah, George S.	Seed, Randolph W.	Schwartz, Franklin
Friefeld, Nathan	Forman, Max	Shapiro, Maynard I.	Schuetz, John N.
Gertz, George	Gardner, Philip M.	Shobris, Martin	Scruggs, Charles
Graham, James F.	Gau, Frederick	Sinaiko, Edwin S.	Seskind, Coleman R.
Green, Martin W.	Gilbert, Hugh	Smith, C. Otis	Singh, Nerissa P.
Guerrero, Severo K., Jr.	Gnade, Gerard R.	Smith, William	Spinka, Harold
Hamilton, Robert C.	Goodman, Harold	Soboroff, Burton J.	Springer, Harry A.
Harrod, John P., Jr.	Gross, Alvin	Solon, Earl N.	Stopka, John E.
Hinkamp, Joseph F.	Gurney, Clifford W.	Sperling, Richard L.	Strohl, Lee H.
Horton, Loren B.	Handler, Jerome L.	Staley, Warren H.	Surath, Vasanth M.
Hrejsa, Allen C.	Head, Louis	Suckow, Earl E.	Thampy, Kishore J.
Hussey, Frank L., Sr.	Hollett, Alan M.	Sugar, Sam J.	Thrasher, Irving D.
Hutchison, William A.	Hussey, Frank L., Jr.	Swartz, Robert M.	Tsatsos, George
Hyde, John S.	Jaffe, Harry J.	Talso, Peter J.	Ungar, Jacob
Jacobs, W. Francis	John, Thomas	Tansey, William J.	Urban, Conrad J.
Jirka, Frank J., Jr.	Jones, Richard	Thompson, J. Robert	Zitek, Russell W.
Joslyn, A. Everett, Jr.	Kass, Harold M.	Tovar, Jorge	
Kalsch, Harry E.	Kerr, William D.	Treister, Michael R.	
Kaz, Alex H.	Kobak, Mathew W.	Turner, George C.	
Kirschenbaum, M. Barry	Koch, Donald	Tworoger, Fred A.	
Kowal, Roland A.	Krolkowski, John R.	Walkowiak, Lydia	
Kozak, John A.	Landau, Richard L.	Waller, Jesse E.	
Kunis, Arthur	Lipsich, Michael	Weigel, Charles J.	
Kwinn, Frank C.	Lucina, Pedro A.	Weingarten, Charles Z.	
Lagorio, George L.	Mahlar, Sandra	Williams, Jack	
Lobraico, Rocco V., Jr.	McCabe, Mary Joan	Xyidakis, Stephanos A.	
Lounsbury, B. Franklin	Mella, Luis	Yanez, Frank	
MacNerland, Robert H.	Mikhail, Kamel A.	Yatvin, Harold	
Marcus, Anna A.	Muehrcke, Robert C.		
Markoutsas, George C.	Munoz, Maria		
Marshall, William	Murphy, Thomas E.		
Mehlinger, Kermit T.	Mustell, Robert R.		

Officers of County Medical Societies

1978

COUNTY	PRESIDENT	SECRETARY
ADAMS Members: 93-Dist. 6 Maxine Boyer, Ex. Sec. 1118 Broadway Quincy 62301	Guenther Gehrich 1101 Maine, Quincy 62301	Richard L. Newman 1124 Broadway, Quincy 62301
ALEXANDER Members: 9-Dist. 9	Gemo Wong 2020 Cedar, Cairo 62914	Charles L. Yarbrough 800 Commercial, Cairo 62914
BOND Members: 9-Dist. 7	M. Kenneth Kaufmann 115 E. College, Greenville 62246	John K. Dawdy 404 Forest Lane, Greenville 62246
BOONE Members: 20-Dist. 12	Maurice J. Carlisle 115 W. Lincoln, Belvidere 61008	John Steinkamp 824 S. Van Buren, Belvidere 61008
BUREAU Members: 35-Dist. 2	James Foresman 204 Park Ave., Princeton 61356	Donald M. Gallagher Box 538, Granville 61326
CARROLL Members: 7-Dist. 12	Basilios Lambos North 4th Street, Savannah 61074	Tadeusz Maciejczyk Milledgeville 61051
CASS-BROWN Members: 2-Dist. 6	R. A. Spencer 115 W. 4th St., Beardstown 62618	B. A. DeSulis 115 W. 4th St., Beardstown 62618
CHAMPAIGN Members: 216-Dist. 8 Larry Booth, Ex. Sec. 1408 W. University Urbana, 61801	Richard B. Helfrich 602 W. University, Urbana 61801	H. Ewing Wachter 2108 W. Springfield, Champaign 61820
CHRISTIAN Members: 25-Dist. 7	E. Doyle Slifer 201 E. Pleasant St., Taylorville 62568	I. Del Valle 311 S. Main, Taylorville 62568
CLARK Members: 7-Dist. 8	Howard G. Johnson Casey Medical Center, Casey 62420	Eugene P. Johnson P.O. Box 68, Casey 62420
CLAY Members: 7-Dist. 7	A. Paul Nancy Flora Clinic, Flora 62839	Donald L. Bunnell Flora Clinic, Flora 62839
CLINTON Members: 11-Dist. 7	James A. Kirby 401 N. Main, Breese 62230	Robert D. Roane 1131 Fairfax St., Carlyle 62231
COLES-CUMBERLAND Members: 44-Dist. 8	H. C. Lin 1700 Wabash Ave., Mattoon 61938	Asit P. Basu 501 Jackson Ave., Charleston 61920
COOK Members: 8570-Dist. 3 Robert Lindley, Ex. Adm. 310 S. Michigan Ave. Chicago 60604	Clifton L. Reeder 734 N. Merrill, Park Ridge 60068	B. Franklin Lounsbury 927 Jackson, River Forest 60305
CRAWFORD Members: 15-Dist. 8	Thomas P. Sloan Schmidt Clinic, Robinson 62454	W. B. Schmidt Schmidt Clinic, Robinson 62454
DE KALB Members: 58-Dist. 12	Stanley D. Brandon Kishwaukee Prof. Bldg., Rt. 23 & Bethany Rd., Box 746, DeKalb 60115	Loren W. Akers Northern Ill. Univ., DeKalb 60115
DE WITT Members: 11-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
DOUGLAS Members: 8-Dist. 8	Walter Steiner 140 W. Sale Street, Tuscola 61953	Humberto Mondul 111 W. South Central, Tuscola 61953
DU PAGE Members: 595-Dist. 11 Lillian Widmer, Ex. Sec. 26 W. St. Charles Rd. Lombard, IL 60148	Thomas W. Stach 120 Oakbrook Center Mall, Oak Brook 60521	James P. Campbell 322 N. Blanchard St., Wheaton 60187

COUNTY	PRESIDENT	SECRETARY
EDGAR Members: 17-Dist. 8	J. R. Shackelford 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
EDWARDS Members: 3-Dist. 9	Paul S. Neirenberg 7 W. Main, Albion 62806	Andrew Krajec 108 W. South St., West Salem 62476
EFFINGHAM Members: 23-Dist. 7	Yong Lee 602 Park Hills, Effingham 62401	Fabio H. Mota 300 N. Maple, Effingham 62401
FAYETTE Members: 7-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kachgal 802 N. Eighth St., Vandalia 62471
FORD Members: 13-Dist. 11	William A. Garrett Sibley 61773	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
FRANKLIN Members: 29-Dist. 9	James P. Durham Benton Med. Clinic, Benton 62812	D. P. Richerson P.O. Box 99, Christopher 62822
FULTON Members: 31-Dist. 4	Marvin E. Schmidt Graham Hospital, 210 W. Walnut, Canton 61520	Marcos A. Arancibia Graham Hospital 210 W. Walnut, Canton 61520
GALLATIN Members: 2-Dist. 9		John E. Doyle Ridgway 62979
GREENE Members: 6-Dist. 6	Jude A. Caselton 9th St., Carrollton 62016	James C. Reid Fillager Mem. Clinic, Greenfield 62044
HANCOCK Members: 12-Dist. 4	Vasant Pawar Memorial Hospital, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
HENDERSON Members: 1-Dist. 4	Silvino Lindo, Jr. Biggsville 61418	
HENRY-STARK Members: 37-Dist. 4	Roberto S. Puentes 100 E. Main, Geneseo 61254	Donald R. Ford 648 N. Chicago St., Geneseo 61254
IROQUOIS Members: 19-Dist. 11		Y. S. Song P.O. Box V348, Watseka 60970
JACKSON Members: 61-Dist. 9	Roger N. Klam Box 2347, Carbondale 62901	Steven A. Nagel 404 W. Main Street, Carbondale 62901
JASPER Members: 2-Dist. 8	Don L. Hartrich 1211 W. Jourdan, Newton 62448	Monico Low 609 S. Van Buren, Newton 62448
JEFFERSON-HAMILTON Members: 34-Dist. 9	Prince B. Oliver Post Office Box 1001, Mt. Vernon 62864	Kenneth A. Peart Doctors Park, Mt. Vernon 62864
JERSEY-CALHOUN Members: 12-Dist. 6	S. S. Kurella McDow Med. Cntr., Maple Summit Rd., Jerseyville 62052	Bernard Baalman Medical Center, Hardin 62047
JO DAVIESS Members: 8-Dist. 12	William Gillies 300 Summit St., Galena 61036	David Hockman 300 Summit St., Galena 61036
KANE Members: 307-Dist. 1 Michael Wild, Ex. Dir. 202 Campbell Geneva 60134	Charles K. Bobelis 860 Summit, Elgin 60120	James R. Downing 157 S. Lincoln, Aurora 60505
KANKAKEE Members: 103-Dist. 11	Morris Lang 1309 E. Court St., Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901
KENDALL Members: 7-Dist. 11	Walter Brill Main St., Oswego 60543	John P. Cullinan Oswego 60543
KNOX Members: 74-Dist. 4	Robert G. Hickerson, Jr. 309 E. Main, Knoxville 61448	J. John Loesch Galesburg Cottage Hosp., Galesburg 61401
LAKE Members: 364-Dist. 1 Julia Schulz, Ex. Sec. P.O. Box 148 Gurnee, Ill. 60031	Joseph L. Burke 2504 Washington St., Waukegan 60085	James R. Creath 2504 Washington St., Waukegan 60085

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LA SALLE Members: 110-Dist. 2	Mavis Schraudenbach 24 Stacy, Streator 61364	Allan L. Goslin 712 N. Bloomington, Streator 61364
LAWRENCE Members: 9-Dist. 8 Ruth Gariepy, Ex. Sec. Lawrence Cty. Mem. Hosp. Lawrenceville 62439	Robert J. Nichols P.O. Box 907, Vincennes, Ind. 47591	Alexander Po R.R. #2, Lawrenceville 62439
LEE Members: 29-Dist. 12	George S. Silvest White Oaks, R.R. 3, Dixon 61021	Tiam H. Lie Castellan, R.R. 5, Dixon 61021
LIVINGSTON Members: 29-Dist. 2	Roger K. Kipfer 109 W. Howard St., Pontiac 61764	Karl T. Deterding 612 E. Water, Pontiac 61764
LOGAN Members: 26-Dist. 5	Glen Tomlinson #4 Doctor's Park, Lincoln 62656	Robert B. Perry 523 N. Elm, Lincoln 62656
MACON Members: 157-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	Paul R. Stanley 418 W. Wood, Decatur 62522	Joseph Schrodt 363 S. Main, Decatur 62523
MACOUPIN Members: 21-Dist. 6	Jose K. Villegas Physicians Bldg., Carlinville 62626	Robert England 224 E. Main, Carlinville 62626
MADISON Members: 178-Dist. 6	Melvin Freedman 2025 Edison Ave., Granite City 62040	Norman E. Taylor 95 S. 9th St., E. Alton 62024
MARION Members: 39-Dist. 7	Hahmid Mahmud 111 E. Rogers, Salem 62881	W. P. Plassman Box 552, Centralia 62801
MASON Members: 6-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	
MASSAC Members 3-Dist. 9	Jack D. Diles Massac Mem. Hosp., Metropolis 62960	Benito Bajuyo P.O. Box 187, Metropolis 62960
MCDONOUGH Members: 35-Dist. 4	Kenneth T. Pawlias 501 E. Grant, Macomb 61455	David Reem 505 E. Grant, Macomb 61455
McHENRY Members: 82-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098	Aniceto M. D'Sousa 1110 Green St., McHenry 60050	Ted L. Rolander 1110 N. Green St., McHenry 60050
McLEAN Members: 116-Dist. 5 Bernyce Carbery Exec. Sec. 401 W. Virginia Normal 61761	Hans Stroink 900 Franklin, Normal 61761	Douglas R. Bey 900 Franklin Ave., Normal 61761
MERCER Members: 6-Dist. 4	Monty P. McClellan 309 NW 2nd St., Aledo 61231	
MONROE Members: 9-Dist. 10	Edilberto F. Maglasang 109 W. Legion, Columbia 62236	Chung H. Khan Route 1, Maeystown Rd., Waterloo 62298
MONTGOMERY Members: 22-Dist. 5	Calixto F. Aquino, Jr. 112 W. Kirkham St., Litchfield 62056	James T. Foster 8 Arrowhead Rd., Litchfield 62056
MORGAN-SCOTT Members: 48-Dist. 6	A. George Schultz 2000 W. Morton, Jacksonville 62650	James Veenstra Passavant Memorial Hospital 1600 W. Walnut St., Jacksonville 62650
MOULTRIE Members: 5-Dist.-7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951

COUNTY	PRESIDENT	SECRETARY
OGLE Members: 15-Dist. 12	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack 915 Caron, Rochelle 61068
PEORIA Members: 332-Dist. 4 M. John Hanni, Jr., Ex. Sec. 427 1st National Bank Peoria 61602	Lorris Bowers 427 1st Nat'l. Bank Bldg., Peoria 61602	Henry Boldt 427 1st Nat'l. Bank Bldg., Peoria 61602
PERRY Members: 15-Dist. 10	Gene Stotlar 13 N. Walnut St., Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
PIATT Members: 5-Dist. 7	George Green 121 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
PIKE Members: 10-Dist. 6	Ansar H. Ansari 203 N. Madison, Pittsfield 62363	T. C. Bunting 321 W. Washington, Pittsfield 62363
PULASKI Members: 1-Dist. 9	A. L. Robinson Box 277, Mounds 62964	
RANDOLPH Members: 21-Dist. 10	Teera Pittayathikhun 818 E. Broadway, Sparta 62286	C. S. Schlageter 818 E. Broadway, Sparta 62286
RICHLAND Members: 25-Dist. 8	Michael E. Murray 1200 N. East, Olney 62450	Peter C. Weber 1200 N. East, Olney 62450
ROCK ISLAND Members: 204-Dist. 4 James A. Koch, Ex. Sec. 612 Kahl Bldg. Davenport, Iowa 52801	James P. Johnston 1630 5th Ave., Moline 61265	E. D. Lardner 3637 23rd Ave., Moline 61265
ST. CLAIR Members: 250-Dist. 10 Ed Belz, Ex. Sec. 4825 W. Main Belleville 62223	Donald L. Jerome 6401 W. Main, Belleville 62223	Paul Rusnack St. Elizabeth's Hosp., Belleville 62220
SALINE-POPE-HARDIN Members: 33-Dist. 9	H. Andrew Cserny 1405 Locust, Eldorado 62930	Warren R. Dammers P.O. Box 281, Harrisburg 62946
SANGAMON Members: 313-Dist. 5 L. R. Brosi, Ex. Dir. 1 N. Old State Capitol Plaza, Springfield 62701	Edward G. Ference 932 S. 2nd St., Springfield 62704	Towfig Arjmand 1209 S. Fourth, Springfield 62704
SCHUYLER Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
SHELBY Members: 8-Dist. 7	Theodore Little 207 S. Pine, Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
STEPHENSON Members: 51-Dist. 12	Edward Maglietta 1036 W. Stephenson, Freeport 61032	Karl Schwiesow 220 W. Exchange, Freeport 61032
TAZEWELL Members: 53-Dist. 5 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	Robert L. Tucker P.O. Box 778, Pekin 61554	Daniel L. Parr P.O. Box 778, Pekin 61554
UNION Members: 10-Dist. 9	Robert L. Rader 200 N. Main St., Anna 62906	William H. Whiting 525 N. Main, P.O. Drawer 559, Anna 62906
VERMILION Members: 97-Dist. 8	Edmund G. Andracki 120 S. Main, Georgetown 61846	L. W. Tanner 7 N. Virginia, Danville 61832
WABASH Members: 6-Dist. 9	T. R. Young 512 Market St., Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863

COUNTY	PRESIDENT	SECRETARY
WARREN Members: 13-Dist. 4	James Marshall 319 N. Main, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
WASHINGTON Members: 6-Dist. 10	Charles Longwell 111 S. Washington, Nashville 62263	Jerry L. Beguelin Box 197, Irvington 62848
WAYNE Members: 7-Dist. 9	S. W. Konarski 101 E. Center, Fairfield 62837	E. Loftin 301 N.W. 11th, Fairfield 62837
WHITE Members: 8-Dist. 9	William Courtnage Carmi Med. Cntr., Carmi 62821	Morris McCall South Plum St., Carmi 62821
WHITESIDE Members: 50-Dist. 12	Timothy Sullivan, Jr. 1716 Locust, Sterling 61081	Roger Hill 101 E. Miller Rd., Sterling 61081
WILL-GRUNDY Members: 232-Dist. 11 Ronald W. Batozech, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	Archibald D. McCoy 57 W. Jefferson, Joliet 60431	Robert L. Kleinhoffer 1415 Maple Rd., Joliet 60432
WILLIAMSON Members: 35-Dist. 9	David L. Sloan Herrin Hosp., Herrin 62948	Herbert V. Fine 110 N. Division, Carterville 62918
WINNEBAGO Members: 389-Dist. 12 Mrs. Johanna Lund Exec. Adm. 310 N. Wyman St. Rockford 61101	George C. Green 4120 Charles St., Rockford 61108	Bernard O'Malley 5670 E. State St., Rockford 61108
WOODFORD Members: 7-Dist. 2	K. Vaicius 511 Oak, Minonk 61760	James W. Riley 109 S. Major, Eureka 61530

No Organized County Society

Johnson
Marshall
Menard
Putnam

Joint County Societies

Cass-Brown	Jersey-Calhoun
Coles-Cumberland	Morgan-Scott
Henry-Stark	Saline-Pope-Hardin
Jefferson-Hamilton	Will-Grundy

ISMS DELEGATION TO THE AMA

Delegates

*To Serve from Jan. 1, 1977 to Dec. 31, 1978
(Elected April 28, 1976)*

Allison L. Burdick, Jr., Chicago
Alfred J. Faber, Chicago
David S. Fox, Chicago
Lawrence L. Hirsch, Chicago
Joseph R. O'Donnell, Glen Ellyn
John J. Ring, Mundelein
Charles K. Wells, Mt. Vernon

*To Serve from Jan. 1, 1978 to Dec. 31, 1979
(Elected April 27, 1977)*

Herschel Browns, Chicago
Howard C. Burkhead, Evanston
Jack Gibbs, Canton
Theodore Grevas, Rock Island
Morgan M. Meyer, Lombard
Joseph Skom, Chicago
Fred A. Tworoger, Chicago

*To serve from Jan. 1, 1979 to Dec. 31, 1980
(Elected April 5, 1978)*

Allison L. Burdick, Jr., Chicago
Alfred J. Faber, Chicago (resigned)
David S. Fox, Chicago
Lawrence L. Hirsch, Chicago
Joseph R. O'Donnell, Glen Ellyn
John Ring, Mundelein
Charles K. Wells, Mt. Vernon

Honorary Delegates

Walter C. Bornemeier, Saratoga, Cal.
Edwin S. Hamilton, Kankakee
Frank J. Jirka, Jr., Barrington Hills
Burtis E. Montgomery, Harrisburg

Delegation Chairman: Jack L. Gibbs; Secretary: Herschel Browns

Alternate Delegates

*To serve from Jan. 1, 1977 to Dec. 31, 1978
(Elected April 28, 1976)*

Andrew J. Brislen, Chicago¹
Audley F. Connor, Jr., Chicago²
Morris T. Friedell, Chicago³
Henrietta Herbolsheimer, Chicago
Robert P. Johnson, Springfield
Eugene T. Leonard, Rockford
Andrew Thomson, Jr., Evanston⁴

*To serve from Jan. 1, 1978 to Dec. 31, 1979
(Elected April 27, 1977)*

Robert R. Hartman, Jacksonville
Eugene P. Johnson, Casey
Lee Johnson, Litchfield

Maynard I. Shapiro, Chicago
Andrew Thomson, Jr., Evanston
Glen E. Tomlinson, Lincoln
Cyril C. Wiggishoff, Chicago
George T. Wilkins, Granite City

*To serve from Jan. 1, 1979 to Dec. 31, 1980
(Elected April 5, 1978)*

Andrew J. Brislen, Chicago
Audley F. Connor, Jr., Chicago
Morris T. Friedell, Chicago
Henrietta Herbolsheimer, Chicago
Robert P. Johnson, Springfield
Eugene T. Leonard, Rockford

¹Elected to fill unexpired term of Fredric D. Lake
²Elected to fill unexpired term of Joseph H. Skom
³Elected to fill unexpired term of Charles Schlageter
⁴Elected to fill unexpired term of Allison Burdick, Jr.

Illinois Delegation

To the American Medical Association

Report to the House of Delegates

The Illinois Delegation introduced 11 resolutions at the 1979 annual meeting of the AMA House of Delegates June 18-22 in St. Louis. Following is the action taken on these resolutions:

Resolution 109—Unfairness of Public Law 94-484, Title VI. The following substitute was adopted:

That the American Medical Association strongly urge the Secretary, Department of Health, Education, and Welfare, to recognize examinations given by the Education Commission for Foreign Medical Graduates (ECFMG) and the Federation Licensing Examination (FLEX) of the Federation of State Medical Boards, Inc., and/or State Board Licensure exam, as equivalent to the Visa Qualifying Examination of the National Board of Medical Examiners for purposes limited to provisions of PL 94-484 for those alien FMGs who have approved or have applied for third preference petitions and possess a valid license to practice medicine in a licensing jurisdiction of the United States prior to January 10, 1977; and That the Board of Trustees study the effects on alien foreign medical graduates and on U.S. institutions providing programs of graduate medical education, of the two-year limit for graduate medical education imposed by PL 94-484 on alien physicians who are temporary residents of the United States (holders of "J" visas) and report to the House of Delegates at the 1979 annual meeting.

Resolution 110—Proposed Changes in Public Law 93-641, Reducing Number of Physicians on HSA Boards. This resolution was amended and adopted as follows:

That the American Medical Association attempt to increase the number of physicians on Health Systems Agency Boards; and

That the American Medical Association con-

tact all Congressmen for the purpose of having them support such changes in PL 93-641.

Resolution 111—Proposed Changes in Public Law 93-641, Extending Certificate of Need Legislation. The House adopted the following in lieu of six similar resolutions:

That the American Medical Association reaffirm its opposition to the extension of Certificate of Need at all levels of government to private physicians' offices; and

That the American Medical Association continue its opposition to the objectionable provisions of HR 10460 and S 2410; and

That the American Medical Association be commended for its efforts to remove the certificate of need and the decertification sections from HR 10460 and S 2410; and

That the AMA, with the assistance of state associations and county medical societies, inform their Congressmen and Senators of our determined opposition to these proposed intrusions by the federal government into the private practice of medicine.

Resolution 112—Proposed National Guidelines for Health Planning by Department of HEW. The House adopted this resolution, which called upon the AMA to request of the Department of Health, Education, and Welfare that, when a guideline discussion is presented in the "Federal Register," the source of the information being presented should be specifically identified.

Resolution 113—Economic Impact Analysis and the Cost of Medical Care Summary Report. The House adopted this resolution, which requested the AMA to seek appropriate legislation to incorporate the economic impact of regulations promulgated by the Department of Health, Education, and Welfare into recommendations for controlling the cost of medical care.

Resolution 114—Key Man Program. This resolution, which called upon the AMA to increase

its present efforts to develop an effective key man program, was referred to the Board of Trustees for report at the 1978 interim meeting. At the same time, the House adopted Report Y of the Board of Trustees, which informed the House of the activities the AMA has undertaken to increase and improve the legislative liaison between the AMA and state medical associations.

Resolution 115—Optometric Services in VA Hospitals. The House referred to the Board of Trustees this resolution which directs the AMA to support the concept that optometric services in all Veterans Administration facilities be directly responsible to their respective departments of ophthalmology and that the AMA communicate this position to the VA Chief Medical Director, and calls for repeal of that section of PL 94-581, Veterans Omnibus Health Care Act of 1976, authorizing creation of separate optometric services.

Resolution 116—Basic Courses in Nutrition. The following substitute was adopted:

That the American Medical Association encourage effective education in nutrition at the undergraduate, graduate and postgraduate levels.

Resolution 117—Amendments to HR 1818. This was referred to the Board of Trustees—with four similar resolutions—with instructions to determine if a new or substitute bill for HR 1818, Comprehensive Health Insurance Act of 1977, is necessary or not; and, if an AMA-sponsored National Health Insurance Bill is to be submitted at the Interim Meeting, it should be circulated to the members of the House of Delegates as early as possible so it may be studied in detail before that session.

Resolution 118—Extending Preferential Treatment to HMOs and Discriminating Against Private Practice. This resolution opposed any efforts to give preferential treatment to HMOs, especially under certificate of need and health planning laws. It was considered together with another similar resolution and with the Board of Trustees response to Recommendation No. 3 of the National Commission on the Cost of Medical Care. The House adopted the following statement in lieu of all three items:

Approval of the concept of neutral public policy and fair market competition among all systems of health care delivery.

It referred to the Board of Trustees the recommendation that it seek an objective assessment of HMOs, including IPAs and other group arrangements, with respect to their impact on access, quality, and cost of health care.

Resolution 119—Blue Cross/Blue Shield Rider. The following substitute was adopted:

That the American Medical Association urge all health insurance carriers and government health care financing agencies to rely on appropriate medical peer review programs for adjudication and resolution of all matters concerning the quality or utilization of medical services which require professional judgment; and

That peer review programs shall have as their goal both improved quality of medical care and more efficient delivery of medical services.

The House also took the following action on two resolutions introduced by Dr. David S. Fox:

Resolution 120—Confidentiality of PSRO Records. Adopted this resolution requesting AMA to seek legislation that would exempt PSROs from the Freedom of Information Act.

Resolution 121—Proposed Revision of Section 9, Principles of Medical Ethics. Referred this resolution, along with several other resolutions and reports of the Judicial Council and Board of Trustees, to a special ad hoc committee on the Principles of Medical Ethics. Dr. Henrietta Herbolzheimer was appointed a member of this committee.

All members of the delegation were present for the meeting in St. Louis, except Dr. Alfred Faber and Dr. Morris T. Friedell. Dr. Herbolzheimer was seated for Dr. Faber and Dr. Robert C. Hamilton received credentials as an alternate delegate. The Delegation has regretfully received Dr. Faber's resignation.

The delegation met on the Saturday and Sunday preceding the opening session of the House of Delegates, interviewing some 30 or more candidates for AMA office or positions on AMA councils. During the week, the delegation met every morning for breakfast to review contents of the Delegates Handbook and reference committee reports.

One of this year's candidates was Illinois' Dr. Robert P. Johnson, who was unsuccessful in his campaign for election to the Council on Scientific Affairs.

Three members of the delegation served on reference committees: Dr. Morgan M. Meyer, chairman of Reference Committee B; Dr. Allison Burdick, Jr., a member of Reference Committee F, and Dr. Fred A. Tworoger, a member of Committee G. Dr. Joseph Skom served as a member of the Committee on Rules and Order of Business.

Jack Gibbs, M.D.
Chairman

Herschel Browns, M.D.
Secretary

ILLINOIS STATE MEDICAL SOCIETY
SCHEDULE OF MEETINGS
INTERIM HOUSE OF DELEGATES

November 4-5, 1978

Wagon Wheel Lodge
Rockton, Illinois

Friday, November 3, 1978

9:30 a.m.	Board of Trustees Meeting
12:00 noon	Board of Trustees Luncheon
5:30 p.m.	Board of Trustees Reception and Dinner
7:30 p.m.	Board of Trustees Meeting

Saturday, November 4, 1978

7:30 a.m.	Board of Trustees Breakfast
9:30 a.m.	ISMIE Board of Governors Meeting
9:30 a.m.	Delegates Registration Opens
10:00 a.m.	Meeting of Reference Committee Personnel
11:00 a.m.	Delegates Check-in with Credentials Committee
12:00 noon	House of Delegates Meeting
1:30 p.m.	District Caucuses
2:30 p.m.	Reference Committee Meetings
5:30 p.m.	Exchange of Ideas on Cost Containment <i>(With Hon. Edward R. Madigan, Member of Congress)</i>

Sunday, November 5, 1978

7:30 a.m.	Board of Trustees Breakfast
8:30 a.m.	District Caucuses
9:00 a.m.	Delegates Check-in with Credentials Committee
9:30 a.m.	House of Delegates Meeting

Committees of the House of Delegates

1978 Interim Meeting

COMMITTEE ON RULES & ORDER OF BUSINESS

Charles J. Weigel, *Chairman* (CMS)

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (four weeks prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

COMMITTEE ON CREDENTIALS

B. Franklin Lounsbury, *Co-Chairman* (CMS)
William C. Perkins, *Co-Chairman* (DS)

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

TELLERS AND SERGEANTS AT ARMS

Lee Johnson, *Chief Teller* (DS)

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

Robert C. Hamilton, *Chairman* (CMS)

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

REFERENCE COMMITTEE A

Charles F. Eddingfield, *Chairman* (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to officers, administration, finances, budgets, economics and peer review.

REFERENCE COMMITTEE B

Joseph B. Moles, *Chairman* (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions and reports relating to government health programs and planning.

REFERENCE COMMITTEE C

J. M. Ingalls, *Chairman* (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to medical service, scientific matters, education and membership services.

REFERENCE COMMITTEE D

William J. Tansey, *Chairman* (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to governmental affairs, medical-legal, and public relations matters.

Resolutions

November, 1978 Interim Meeting

House of Delegates

<i>Number</i>	<i>Subject</i>	<i>Introduced By:</i>
78N-1	Medical School Admissions and Physician Shortage Areas	M. Barry Kirschenbaum, M.D.
78N-2	Government Influence on Cost of Medical Care	M. Barry Kirschenbaum, M.D.
78N-3	Revision in Policy Statement on Professional Liability	Lawrence L. Hirsch, M.D. for the Board of Trustees
78N-4	Deletion of Policy Statement on Medical Representation in Government Planning	Lawrence L. Hirsch, M.D. for the Board of Trustees
78N-5	Revision of Policy on Committee Appointments	Lawrence L. Hirsch, M.D. for the Board of Trustees
78N-6	Deletion of Administrative Policies—Education, Primary and Secondary; Facility Medical Boards (Physicians); and Federal Funds—from the Policy Manual	Lawrence L. Hirsch, M.D. for the Board of Trustees
78N-7	Revision of Policy Statement on Specialty Society Representation on ISMS Councils	Lawrence L. Hirsch, M.D. for the Board of Trustees
78N-8	Deletion of Relative Value Statement from Policy Manual	Lawrence L. Hirsch, M.D. for the Board of Trustees
78N-9	Revision of Public Aid Statement in Policy Manual	Lawrence L. Hirsch, M.D. for the Board of Trustees
78N-10	Deletion of Statement on Nurses' Shortage from Policy Manual	Lawrence L. Hirsch, M.D. for the Board of Trustees
78N-11	Deletion of Statement on Fee Schedules from Policy Manual	Lawrence L. Hirsch, M.D. for the Board of Trustees
78N-12	Deletion of Ethics Statement from Policy Manual	Lawrence L. Hirsch, M.D. for the Board of Trustees
78N-13	Revision of Policy Statement on Comprehensive Health Planning	Lawrence L. Hirsch, M.D. for the Board of Trustees
78N-14	Deletion of Community Health Week Statement from Policy Manual	Lawrence L. Hirsch, M.D. for the Board of Trustees
78N-15	Amendment to Chapter IX, Section 2, of the Bylaws Revising Areas of Concern of Council on Economics and Peer Review	James Laidlaw, M.D. for the Board of Trustees
78N-16	Amendment to Chapter IX of the Bylaws Describing the Committee on Third Party Payment Processes	James Laidlaw, M.D. for the Board of Trustees

<i>Number</i>	<i>Subject</i>	<i>Introduced By:</i>
78N-17	Amendment to Chapter IX of the Bylaws to Describe the Areas of Concern of the Council on Medical Service	James Laidlaw, M.D. for the Board of Trustees
78N-18	Amendment to Chapter IX of the Bylaws Expanding the Charge to the Council on Affiliate Societies	James Laidlaw, M.D. for the Board of Trustees
78N-19	Streamlining Operation of the Interim Session of the House of Delegates	P. John Seward, M.D. for the Board of Trustees
78N-20	Lowering Malpractice Insurance Rates as Cost Containment Measure	Samuel J. Schimel, M.D.
78N-21	IMJ Publication of Clinical Materials from ISMS-Sponsored Meetings	Robert R. Hartman, M.D. for the Board of Trustees
78N-22	How Then Shall We Define Life?	H. Frank Holman, M.D.
78N-23	Resident Delegate from Illinois to AMA House of Delegates	James DeBord, M.D. for the Resident Physician Section

For further information about the 1978 Interim Meeting, please contact the ISMS offices.

Doctor's News

SPECIAL PROGRAM ON ALCOHOLISM—The ISMS Student Business Session plans to hold a special educational program in alcoholism treatment during the AMA Interim Meeting. The program, sponsored by a grant from the Illinois Department of Mental Health and Developmental Disabilities, Division of Alcoholism, is scheduled for Friday afternoon, December 1, 1978, at the Palmer House, Chicago.

Members of the ISMS Scientific Speakers Bureau Alcoholism Roster will discuss several medical aspects of alcoholism. Topics will include acute care for crisis intervention and withdrawal, fetal alcoholism syndrome, and the increasing problem of teen drinking.

All interested parties are invited to the program, which will carry three hours of Category 2 CME credit for physicians. There is no admission fee. For further information, contact the ISMS offices.

ARTHRITIS AND RHEUMATOLOGY have been added to the list of available topics in the Southern Medical Association Dial Access System. The Dial Access, is a system of taped messages giving diagnostic and therapeutic information, which are available to physicians through a toll-free telephone number. A program on infectious diseases is planned in coming months.

If you are interested in obtaining a copy of the catalog listing of diagnostic messages from Dial Access, please write the SMA offices at 2601 Highland Avenue, Birmingham, Alabama 35205.

EPIDEMIOLOGY FELLOWSHIPS AVAILABLE—The University of Illinois School of Public Health has announced that both pre- and post-doctoral fellowships are available for study of the epidemiology of cancer and other environmental health problems. The fellowships, supported by the American Cancer Society and the National Institute of Environmental Health Sciences, include tuition and fees, stipends, and some research expenses.

For further information, contact Dr. H. M. Gelfand, Director, Epidemiology Program, School of Public Health, University of Illinois, P.O. Box 6998, Chicago 60680.

NEWS FROM TEXAS—Two studies from the University of Texas M.D. Anderson Hospital and Tumor Institute have brought evidence that protected environments reduce the risk of infection for cancer patients, particularly those with acute leukemia and malignant lymphoma. (Infection has been found to be the cause of death in 75% of the former and 50% of the latter group). Protected environments, the study found, greatly reduced the infection risk and permitted more intensive treatment, thus increasing the chances for a complete remission. Gerald P. Bodey, M.D., medical director of the Clinical Research Center that includes the special protected unit, was quoted reporting a 90% complete remission rate for first remission and the lowest incidence of infection ever recorded at that hospital. (The treatment includes antibiotics within the protected environments during chemotherapy).

PHYSICIANS IN THE NEWS—Robert S. Blacklow, M.D., former associate dean at Harvard, has been named vice president for medical affairs and dean of Rush Medical College. . . . Robert K. Anzinger, M.D., Chicago, has been elected to the American College of Emergency Physicians' Board of Directors. . . . Leo M. Henikoff, M.D., was recently elected vice president for Inter-Institutional Affairs at Rush-Presbyterian-St. Luke's Medical Center in Chicago. Dr. Henikoff will be responsible for liaison within the medical center, seven affiliated hospitals and three associated institutions, as well as an academic network including 14 colleges and universities in six states.

DOCTORS INVOLVED IN POLITICAL PROCESS—*IMJ* recently received notice of the candidacy of Edmund R. Donoghue, M.D., for trustee of the University of Illinois. Doctor Donoghue, vice chairman of the department of surgery at St. Joseph Hospital in Chicago and former chairman of that department as well as a former president of the medical staff, is optimistic about his candidacy. A teacher and lecturer who has been affiliated with the Northwestern, Loyola and Chicago Medical schools, Doctor Donoghue has emphasized the need for a physician on the UI Board of Trustees. Of the total UI budget, he has said, 30% is allocated to the medical school and allied health sciences. But no current UI Trustee has attended medical school.

Although no physicians are currently listed on the roster of Illinois legislators, physician's spouses are included. Michael A. Abramson, (R)-Chicago, and Mary Lou Sumner, (R)-Dunlap, are among those who meet these qualifications. In addition, Edward E. Bluthardt, (R)-Schiller Park, is a physician's son, as is Illinois Governor James R. Thompson.

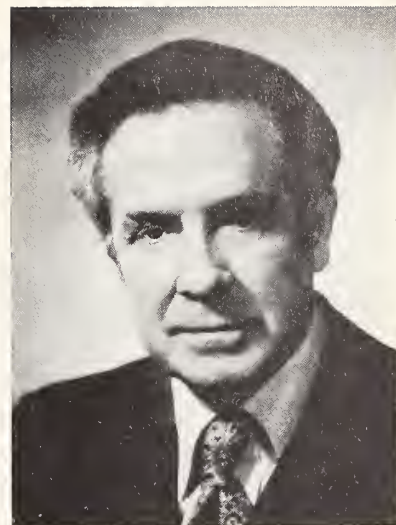
ATTENTION, GENEALOGY BUFFS—A special lecture is scheduled for Saturday, October 28, at the Prospect High School Auditorium, 801 Kensington Road, Mount Prospect, IL., at 1:30 p.m. James Hansen, reference librarian for the Wisconsin State Historical Society Library will discuss the genealogical holdings and activities of that group. Tickets are \$5.00. For further information, telephone 312-253-1700, or write to: Continuing Education Office, 799 W. Kensington Road, Mount Prospect, IL 60056. (Please make checks payable to "Township High School District 214).

GERIATRIC PSYCHIATRY GAINS EMPHASIS—The National Institutes of Health have extended a three-year training grant in geriatric psychiatry to Jack Weinberg, M.D., a professor of psychiatry at Rush-Pres.-St. Luke's Medical Center and Lawrence Lazarus, M.D., an assistant professor at Rush and psychiatric consultant to the Johnston R. Bowman Health Center for the elderly.

NEW CME PUBLICATIONS—The Illinois Council on Continuing Medical Education has announced that two new free publications are available. "Setting Directions in CME, Purpose, Goals & Objectives," and "CME Planning Checklists," are the two new, helpful "how to do it" publications. A charge of \$4 per copy for the first and \$3 per copy for the second booklet will be assessed for interested parties who are neither ISMS members nor CME Sponsors. Further information may be obtained by writing the Illinois Council on Continuing Medical Education, 55 E. Monroe St., Chicago 60603.

President's Page

Interim Session To Focus On Key Issues



Next month's interim session of the ISMS House of Delegates will focus on key issues confronting the profession, and also on the Society's method of dealing with them.

Among the subjects of debate will be our stance concerning introduction by AMA of another NHI bill; recommendations of the National Commission on the Cost of Medical Care; and the Voluntary Effort to control health costs. Another key issue will be the structure of the interim session itself.

When the number and magnitude of volatile issues began increasing, the interim session was created as a logical method of allowing timely action by the policy-making House of Delegates. These shorter meetings were designed to focus on one or two issues. However, with each successive session, the scope and volume began to resemble that of the annual meeting—defeating to some degree the original purpose.

The interim session is an important part of the ISMS policy-making process. It ensures that the Society's leadership has the benefit of membership input while an issue is still considered "hot." The volume and diversity of resolutions now are threatening the ability of the House to deal with each subject during the abbreviated interim meeting. In an effort to preserve the two-day format, the Board of Trustees will submit a recommendation to streamline the meeting. The Board's suggestions will be presented in a resolution which, if adopted, will limit the scope of deliberation.

Under the proposed revamping, only matters deemed urgent by the Board of Trustees, AMA delegation or the Committee on Rules and Order of Business would be accepted for consideration, although any proposal would be considered after approval by a two-thirds majority of the House. Resolutions postponed as less than urgent automatically would be placed on the agenda for the House's annual meeting.

To ensure that your views are adequately represented on all issues, urge your delegates to attend the November meeting. Only through widespread participation can ISMS remain an effective voice for Illinois physicians. ◀

A handwritten signature in dark ink that reads "David S. Fox". The signature is fluid and cursive, with a large initial "D" and "F".

David S. Fox, M.D., President

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

Announcing . . .

The 1978 DOCTOR'S JOB FAIR December 10, 1978 Sheraton-OakBrook Hotel

For further information contact:

Physician Recruitment Program
Suite 3510 — 55 E. Monroe
Chicago, IL. 60603
312-782-1654

ARCOLA: Wanted-American trained F.P. to join established F.P. in active practice. Must do some O.B. Guaranteed salary and benefits. Eventual partnership. Robert N. Arrol, M.D., 126 S. Locust, Arcola, 61910. (217) 268-4444, or 268-4404. (12)

ATKINSON: Due to recent death of town's physician, a modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles from Peoria. All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235. (309) 936-7566. (12)

AURORA: Opening in General Internal Medicine with 40 man group. Complete office facilities. Good starting salary. Contact: L. E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506. (312-859-6700) (1)

CHICAGO: Opportunities Available for Family Practitioners in a single specialty clinic setting. Association as a satellite facility with a 265 bed community hospital. Opportunity to build own practice with financial assistance available. Contact: Teryl R. Filebark, 1044 N. Francisco Ave., Chicago 60622. (312) 278-8800. (9)

CHICAGO: Major Chicago based retailer seeking corporate physician. Up-to-date, modern facilities, regular hours and comprehensive employee benefits make this

a very desirable position. Please send resume with salary requirements. Contact: Professional Employment Director, Sears, Roebuck & Co., D/707-2, Chicago 60684 (1)

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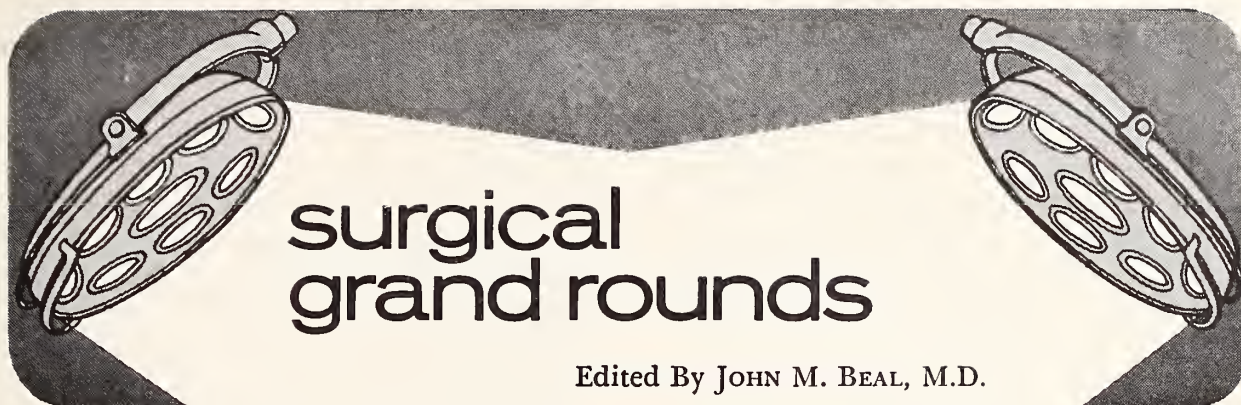
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Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of November 22, 1977.

Case Report

Torsion of the Testis

Dr. John Sommer: A 25-year-old man was admitted to the Northwestern Memorial Hospital with five hours of right lower quadrant pain, which subsequently localized to the right testicle. The pain was later described as radiating from the testicle into the right lower quadrant. He had experienced some nausea but no vomiting. He had neither urinary complaints nor prior testicular pain.

He was afebrile at the same of physical examination. His abdomen was soft with some mild tenderness in the right inguinal region. The penis was normal and the right testicle was elevated in the scrotum. Skin overlying the testicle was somewhat edematous and slightly warm. The position of the epididymis on this side was normal and the testicle was swollen and tender. Rectal examination and examination of his prostate was also normal. His urinalysis was unremarkable and he had a white blood cell count elevation of 12,200. The impression was a torsion of the right testicle. He was taken to the operating room where a right transverse scrotal incision was made under general anesthesia.

A moderate amount of hydrocele fluid was removed. A 360° counter-clockwise rotation of the testicle, intravaginally, was found. The testicle itself was swollen and cyanotic. It was dero-

tated and fixed to the dartos. After this, the left testicle was attached to the dartos in a similar manner through a separate left scrotal incision.

This patient is a little older than the typical patient with torsion of the testicle. This problem usually is seen around the age of puberty. It is not really a torsion of the testicle, but should be properly termed torsion of the spermatic cord. The torsion of the cord causes loss of the vascular supply to the testis.

There are two forms of torsion of the testicle. The most common is the intravaginal form, as in this case. In this form, the testicle twists within the tunica vaginalis because of anomalous suspension. A less common type is extravaginal torsion. This is primarily a problem in newborns. The newborn testicle is very mobile and the tunica have not become attached to the scrotal wall. In the extravaginal torsion, newborns present with a painless mass in the scrotum and discoloration of the scrotal wall. Exploration should be performed promptly so that the torsion can be corrected with attachment of the testicle to the scrotal wall.

The more common form, intravaginal torsion, is secondary to anomalous testicular descent. Normally, the anterior half of the testis is covered by tunica vaginalis, leaving the posterior

surface bare to form loose attachments to the wall of the scrotum. All the anomalies in the intravaginal torsion occur because of this anomalous suspension of testicle. As more than half of the testicle is usually covered by the tunical vaginalis, the testicle can thwart within the tunica vaginalis as a bell clapper. Anomalies of the epididymis, such as a partial attachment to the epididymis or a complete separation of the epididymis from the testicle can also be contributory, so the torsion can occur between the epididymis and the testicle. This may occur at any age, most commonly at puberty. The current high occurrence at puberty is attributed to differential size and growth of the testicles.

Symptoms can be a sudden onset of pain or an insidious gradual onset, which often occurs during sleep. It is estimated that there is an absence of previous testicular pain in 50% of reported cases. Pain usually progresses to become moderately severe and can radiate into the groin, lower abdomen and also into the lumbar area. There can be nausea and vomiting. Fever is not usually a symptom. Urinary symptoms are varied and frequent. On physical examination, the testicle is usually drawn up high in the scrotum on the affected side. The position of the epididymis is not always abnormal. If the testicle, as in this case, is rotated 360°, the position is normal. In epididymitis, elevation of the testicle should reduce the pain, but in torsion of the testicle, elevation should increase the pain.

Differential Diagnosis

The real problem is differentiation from acute epididymitis, incarcerated hernias, acute hydroceles and mumps. The recent history of parotiditis or of mumps in the family or mumps in the peers should be present. In epididymitis, pyuria should be present. Another distinguishing feature of torsion is that the testicle is raised in the scrotum. In torsion, the edematous mass of the spermatic cord is softer than the mass of acute epididymis. Abnormal suspension of the opposite testicle may be present, which will also indicate a similar abnormality of this affected side. Usually, it is an abnormality of one side or the other. There is a 50-80% chance of an abnormality of the opposite testicle.

In the emergency room, it is reported that people have been able to detort testicles. In theory, this sounds good; in practice, it is probably difficult because the testicle can rotate in either direction and rotate several times.

The standard operation is detorsion, fixation

to the dartos, and exploration of the other side. I would like to mention the torsion of the appendices of the testicle. There are essentially four different testicular appendices, and again these most commonly occur around puberty. The appendix testis is the most common and normally occurs in 90% of normal individuals. The second is the appendix epididymis, which occurs in 30% of individuals. Thirdly, the paradidymus is an accessory appendix of the vas deferens, and fourthly, the vas aberrans of Haller attached to the epididymus.

Symptoms of torsed appendices include acute onset of pain. The pain may be markedly debilitating. If seen early, this pain may be sharply localized to the torsed appendix. There is a physical sign, called the "blue dot sign" in which a blue dot of the infarcted appendage may be seen through the scrotal skin. If seen early, the torsed appendage may be palpated as a swollen tender mass. Later torsion of the appendage often has a red rash edema and later an inflammatory hydrocele. It is hard to differentiate from torsion of the testicle. Some people who have been sure of the diagnosis of torsion of an appendix have treated these patients conservatively. This is not recommended because pain from this is severe and debilitating for long periods of time; usually at least a week. The patient can be explored through a small scrotal incision and have the torsed appendix ligated.

New Diagnostic Tools

I should mention two newer things in diagnosis of torsion of the testis. One is a scanning. This is done with Technetium-99 and having a scan taken about 10 minutes after the isotope is injected. The torsed testicle should appear as an oval area of decreased uptake. The main disadvantage is that scans are not available on a 24-hour basis and are difficult to schedule as an emergency. The survival of the testicle is considerably greater if surgery is initiated within the first seven hours. Probably these scans will increase the delay in therapy. The second thing is the use of the Doppler ultrasonic stethoscope. The Doppler examination is interesting in that you have the opposite testicle as a control. This is done by placing the Doppler on the anterior surface of the testicle. Normally, pulsations are heard over the testicle and will cease when the blood supply in the spermatic cord is compressed. In torsion of the testicle, pulsations will be absent. You can check this by compressing the blood supply of the opposite testicle to see if

pulsations will cease. There are two problems with the Doppler. (1) In the early torsion, only the venous return is compromised and (2) in more chronic forms, there are false readings because of the increase of blood to the area from inflammation.

Dr. Earl Wendel: In acute scrotal pain and swelling, it is basically better to explore the scrotum if there is a question of diagnosis. None of the newer diagnostic modalities are really that accurate. The average age in the group that present with torsion is about 14 to 18 years. Interestingly the changes are about 1 in 160 that a young male will reach the age of 25 having a torsion; it is fairly common entity. There are a number of things that predispose to it, among which are abnormal genital attachments. Terms that are sometimes used in reference to testicular abnormalities are the horizontal or transverse lie and the bell clapper deformity. These are basically anatomic abnormalities that predispose to a testicle undergoing torsion which relate to abnormal attachments in the scrotum.

The testicle, as most of you know, hangs in a fairly perpendicular position in the scrotum. If you are looking at a person from the side, the epididymis is more posterior than lateral. There really is something to the gubernaculum. There are attachments inferiorly and if you look at the scrotum straight on with the two scrotal compartments, the epididymus is more lateral. There is some posterior and medial attachment where the tunica vaginalis doesn't completely encompass this area. However, the tunica vaginalis can attach way high on the spermatic cord, so that the testicle really swings free. That is called the "bell clapper" deformity because it hangs free inside the tunica vaginalis.

Another common anomaly is called the transverse or horizontal lie, where there is such poor attachment to the testicle that it is mobile in the scrotum and you can actually spin these around if you choose, while you are examining them. Because the testicle is not attached at all, the testicles frequently assume a lie that is more or less transverse; instead of being perpendicular, it ends up going actually horizontally. Those frequently undergo recurrent twisting. Forty or 50% of the men with acute torsion will give a history of genital pain episodes, possibly due to a torsion that reduces spontaneously. They do reduce spontaneously and it has been said that the majority of them undergo detorsion or untwisting spontaneously at the time of induction of anesthesia. Certainly, 60 or 70% will untwist when you put the patient to sleep. There is a

lot of crevasteric spasm that keeps this thing twisted rather than allowing it to relax.

The hallmarks are basically young males that present with acute scrotal pain and then begin to have swelling. If they haven't swollen too significantly, you can usually find an abnormal position of the testicle. The testicle may be riding high in the scrotum or there may be thickening of the cord where the twist actually is. If there is evidence of genital infection, it is more likely that they have epididymitis. However, if there is any doubt whatsoever, they should be explored, because the risk of exploration is really minimal (excepting the anesthetic). The salvage of the testicles with torsion is still only about 40 to 50% and the other half are lost due to late exploration, or non exploration.

Dr. John Beal: This is an important subject because it is usually an acute emergency and anyone might encounter it in the emergency room. As Dr. Wendel has just said, if it is not treated promptly, it causes the loss of the testes.

Dr. James Hines: When you mechanically detorse one in the emergency room without operating or it detorses itself, I want it made clear, do you then go back and do a fixation?

Dr. Earl Wendel: On both sides. I think that is important to emphasize. ◀

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Rheumatology Rounds

L. F. Layfer, M.D., and J. V. Jones, M.D., Contributing Co-Editors

Acute Unilateral Ankle Swelling With Fever

A 65-year-old retired housekeeper was seen for right ankle swelling. Two days earlier she had awakened with a dull ache in her ankle. Pain was constant and intensified with walking, which rapidly became impossible. Warm soaks were not helpful and aspirin gave only minimal relief.

There was no history of trauma. She had experienced similar ankle pain ten years earlier but this had been milder and had abated within two days without treatment. Except for occasional knee stiffness, she had no other joint complaints. Other past history and review of systems revealed mild hypertension currently treated with a thiazide diuretic.

On examination, oral temperature was 38°C and blood pressure was 130/80. The right ankle was warm, erythematous and tender to even mild palpation. Pain was increased by ankle motion. Swelling was noted anteriorly and about both malleoli. The heel, midfoot, and forefoot were normal. The knees revealed mild crepitation but were otherwise normal. Other joints and the rest of the physical exam were unremarkable.

Laboratory

Hematocrit was 39%. White blood count was 8700 with 58% polymorphs. SMA 18, coagulation studies, EKG and urinalysis were normal. Repeat values for calcium, phosphorous and uric acid were consistently normal. Blood and urine cultures were sterile. Chest X-ray was normal. X-rays of the right ankle were unrevealing. Joint aspiration revealed grossly turbid synovial fluid appearing purulent; mucin clot and viscosity were fair; white cell count was 32,000 with 63% polymorphs; glucose was normal; gram stain revealed rhomboid shaped crystals in white cells but no bacteria. Under polarized light examination, positively birefringent rhomboid shaped crystals were identified. Synovial fluid cultures were sterile.

Comment

Rheumatic syndromes associated with calcium pyrophosphate dihydrate (CPPD) crystal deposition in articular cartilage are combinations of three basic manifestations of such deposition.¹ When calcium crystal deposits become dense enough to be seen roentgenographically, the X-ray picture of chondrocalcinosis² is produced. Common sites for this are menisci and articular cartilage of the knee, triangular cartilage of the wrist, and the symphysis pubis. (Fig. 1 and 2) Other joints and even intervertebral discs are occasionally involved. When CPPD crystals are shed from cartilage into synovial fluid, an acute inflammatory response similar to that produced by urate crystals is manifested. Attacks most commonly take the form of an acute monoarticular arthritis of large joints resembling gouty attacks (hence the name "pseudogout"), but may also be polyarticular and subacute, resembling other common inflammatory arthritis conditions.³ Such attacks are not limited to joints which have chondrocalcinosis on X-ray. Also associated with CPPD deposition is the simultaneous degeneration of cartilage. This results in clinical and radiographic pictures similar to osteoarthritis of the involved joint. Occasionally the degeneration may be severe enough to resemble a charcot or neuropathic joint.

Diagnosis of CPPD deposition states is made by typical X-ray pattern of calcification in peripheral joints and by identification of positively birefringent rhomboid crystals in synovial fluid under polarized light.⁴ Any ordinary microscope may be readily adapted for use as a polarizing instrument with little expense.⁵ Crystals are visible by gram stain under oil immersion, but identification of type of crystal (eg: urate or CPPD) is not possible by this method. Other causes of rheumatic disease must be ruled out.



Figure 1

Chondrocalcinosis of the knee: typical calcification can be seen in the fibro- and hyaline cartilage (arrows).

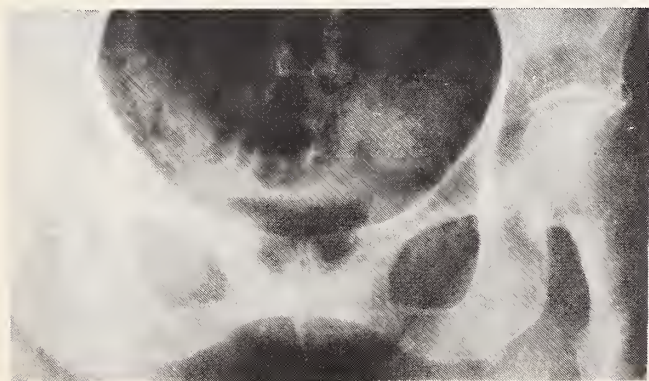


Figure 2

A thin line of calcification can be seen in the symphysis pubis.

Attacks of pseudogout may occasionally occur simultaneously with such diseases.

The cause of CPPD deposition is unknown. Several metabolic diseases have been associated with it (Table 1) but as yet no clear biochemical abnormality leading to such deposition has been described.

Table 1

Diseases Associated with CPPD Deposition	
Idiopathic	Ochronosis
Familial	Gout
Hyperparathyroidism	Diabetes Mellitus
Hemochromatosis	Hypothyroidism
Wilson's Disease	Hypophosphatemia

Therapy is non-specific.³ Acute attacks are treated in the same way as are acute attacks of gout. Short courses of indomethacin, phenylbutazone, or systemic or local corticosteroids are generally effective. Colchicine may occasionally give relief but is not uniformly effective. At present, there is no prophylaxis against recurrent acute attacks. Degenerative joints are treated with medical and surgical regimens similar to those used for osteoarthritis. Associated metabolic diseases should be sought and treated appropriately. It is not yet clear whether treating an underlying associated disease will influence the course of the CPPD-related articular disease.

Conclusion

The finding of crystals in synovial fluid typical for CPPD suggested an acute pseudogout attack as the etiology of the ankle symptoms in the present case. Subsequent X-rays of knees, wrists, and pubis showed typical chondrocalcinosis consistent with such a diagnosis. An associated metabolic disease could not be found. The patient was treated with bed rest and high dose indomethacin. Marked reduction in swelling occurred within 48 hours and complete resolution within 96 hours. She was discharged on no medication, and on six month follow-up had no recurrent attacks. ◀

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Report on the 1978 AMA-RPS Annual Meeting

BY LINDA L. HUGHEY, M.D./WILMETTE

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

Chairman's Report

As chairman of the Illinois Resident Physician Section, requests for resident participation in various national committees frequently come to my attention.

I would like to pass some of these opportunities on to the resident membership at large in hope that Illinois could contribute resident input to various policy-making organizations.

For example, there will soon be an opening for a resident on the Commission on Emergency Medicine. The following AMA councils seek residents for openings that will occur in June, 1979.

Council on Constitution & Bylaws
Council on Medical Services
Council on Scientific Affairs
Council on Legislation

The commission is seeking a "non" emergency medicine resident. Members of the AMA councils will be elected in June, 1979, except for the resident member of the Council on Legislation, who is appointed by the AMA Board of Trustees.

For further information, call C. Jay Brown at AMA in Chicago 312-751-6786.

These AMA councils make policy for the 70,000 interns and residents throughout the country and, therefore, resident input is critical.

Ira Isaacson, M.D.
Chairman, ISMS/RPS

Dates to Watch

Nov. 4-5 (Sat.-Sun.) ISMS Interim Meeting at the Wagon Wheel Lodge, Rockton, Ill. Opening session starts at noon on Nov. 4. If you are interested in attending and/or car pooling to meeting, please contact Perry Smithers at the Illinois State Medical Society office and one of the ISMS RPS officers will contact you. Some RPS funds

may be made available to cover expenses of residents wishing to attend.

Dec. 10: "Doctor's Job Fair" co-sponsored by the ISMS. Watch future columns for details.

Dec. 1-2: American Medical Association Resident Physician Section (AMA-RPS) annual meeting in Chicago. Delegate positions are available; please contact Dr. Ira Isaacson through the ISMS if you would be interested in attending.

Cost Containment Commentary

Omnimedical Services, Inc. introduced a brain scan machine last November which cost \$120,000 as opposed to the usual going rate of \$350,000. This CAT scanner was called the "Omni 4001," in a not-so-subtle reference to a California Assembly Bill 4001 which required hospital certification for any purchases above \$150,000. The new scanner brings up several cost containment issues:

- 1) Does decreasing the initial cost of a technical device make total costs increase by causing utilization to increase?
- 2) Are hospitals installing these expensive and sophisticated machines because of a real need for them or because they represent a high-income test?
- 3) Are residents and young physicians in any way contributing to the trend toward "a CAT-scanner in every hospital" by *expecting* advanced technology as a prerequisite to setting up practice in a given area?

Almost all residents are trained in fairly large, advanced medical centers. Having trained at an institution where obtaining an EMI scan is often easier than doing a spinal tap, it is small wonder that residents going in to practice tend to gravitate towards centers which offer more sophisticated support services. Should we or can we do anything about the trend?

Viewbox

(Continued from page 185)

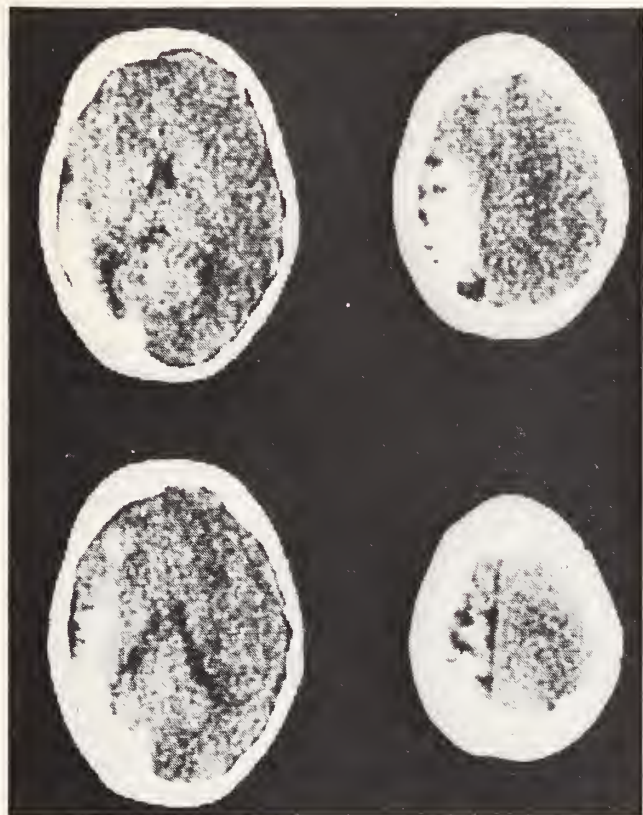


Figure 2

DIAGNOSIS: Sturge-Weber Syndrome

The skull films show superficial "tram track" calcifications in the parieto-occipital area. These are clearly intracranial and could not be caused by material in the hair.

Intracranial tumors (meningiomas, astrocytomas, oligodendrogliomas) usually exhibit rather coarse and poorly defined calcification; meningeal calcifications of inflammatory origin are usually basal in location and when situated over the convexity are diffuse and poorly defined.

The Sturge-Weber Syndrome is congenital and characterized clinically by unilateral angiomatic lesions of the face, hemiparesis of the opposite side, mental retardation, and seizures.

The gyriform calcifications seen on the skull

X-rays are subcortical and can be seen on the C.T. scan (Figure 2). They are associated with angiomas of the leptomeninges which are usually parieto-occipital in location.

This case is presented in order to remind the reader of the clinical and radiological manifestations of this rare entity and its rather pathognomonic features.

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Case Report

Phencyclidine Psychosis

BY BEVERLY J. FAUMAN, M.D. AND MICHAEL A. FAUMAN, M.D., Ph.D./CHICAGO

Phencyclidine abuse has been increasing throughout the United States during the past ten years, predominantly among adolescents and young adults. A very small number of those who experiment with this drug develop a psychosis which characteristically persists for several weeks. In most of these patients, a history of poor premorbid function is found. A previously healthy 39-year-old man with no personal or family history of psychiatric disturbance developed a psychosis requiring several weeks' hospitalization after smoking a "reefer." The history and the hospital course suggest that this was most likely phencyclidine. The authors suggest that with the increasing use of phencyclidine, even psychologically healthy people who are not typical drug users may develop a phencyclidine-related psychosis.

Phencyclidine, one of the most common illicit drugs in many cities¹⁻³ has been increasingly available as a drug of abuse since 1967.⁴ Various reports have been published concerning its biochemistry, adverse effects, and acute and prolonged psychoses.^{2,5-9} The typical user is a young person between 15 and 25 years of age, although adverse effects have been reported in patients ranging in age from 10 months to 33 years. The prolonged psychosis is an infrequent occurrence, generally affecting patients with a history of poor premorbid psychological adjustment. This report concerns a phencyclidine-induced psychosis in a previously healthy 39-year-old man.

The patient was a professional, married and the father of four. He was brought to the emergency department by his brother, who re-

ported that there had been an abrupt change in the patient's behavior five days earlier, when he returned from a night out. He was thought to have smoked marijuana that night, although there was no history of excessive drug use. The abnormal behavior consisted of "moodiness," crying spells, sleeplessness, and apparent auditory hallucinations.

Several events were thought by the brother to be contributing to the patient's illness. He had been having an affair, which the wife had insisted he break off on the day of his behavior change; also his oldest son, who he had hoped would go to college, had instead left home two weeks earlier to join the service. There was some history of heavy drinking in the past, but none in recent months. There was no family or personal history of psychiatric illness. The patient had smoked marijuana on rare occasions with his sons.

The patient himself was unable to give any history on admission, although he had a perception that something was terribly wrong with his head. On physical examination he was an overweight, well-developed man appearing his stated age. Blood pressure was 172/120, pulse 96. He appeared anxious, was hyperalert and easily distractible. The remainder of the physical examination was within normal limits, except for an equivocal plantar response on the right.

Most strikingly, he appeared to

understand questions and commands, but responded each time with a delay of 20 to 30 seconds. He was oriented to time, place and person, but had difficulty performing memory tests and had a very incomplete memory for the events of the previous five days. Calculations, judgements and abstract thinking could not be tested adequately because the patient grew increasingly agitated as his mental difficulties were demonstrated.

Treatment

He was admitted to the inpatient psychiatric unit, where he improved gradually over the next three weeks. Initial improvement seemed directly related to placing him in isolation. All laboratory tests were normal, including liver function tests, computerized axial tomography of the brain, EEG, blood alcohol and carbon monoxide level. Blood and urine screen revealed no drugs. Lumbar puncture was attempted unsuccessfully on two occasions. Plantar reflex became normal on the second hospital day.

On the 12th hospital day, the patient described the precipitating event. He had been out with several friends when one of them passed around a "reefer." He realized that he was not "handling it well" and was upset by his inability to explain to his friends that he was having a bad experience. He began having accusatory auditory

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hallucinations and became increasingly confused, a state which lead finally to his hospitalization.

Summary

The phencyclidine psychosis is an extremely uncommon phenomenon. Susceptibility to a prolonged psychosis is generally related to a poor premorbid history, as is true of the psychosis induced by other illicit drugs. It is unusual to find such a severe reaction in a middle-aged, previously healthy patient. However, there are several features that characterize the reaction as an organic brain disorder.¹⁰ The sudden onset and relatively rapid recovery, with confusion and agitation as the major symptoms are prime criteria. The history of smoking "reefer," which commonly is mixed with or is phencyclidine, and the observation that isolation brought about improvement, strongly suggest phencyclidine.^{11,12} The setting of marital troubles and the recent departure of the oldest child probably contributed to the pa-

tient's susceptibility to a psychotic reaction. It is important for physicians to be aware of this entity, and the possibility of its occurrence in a previously well middle-aged person who is not a typical drug user. The evidence suggests that we will continue to see phencyclidine abuse increase.

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EKG

(Continued from page 188)

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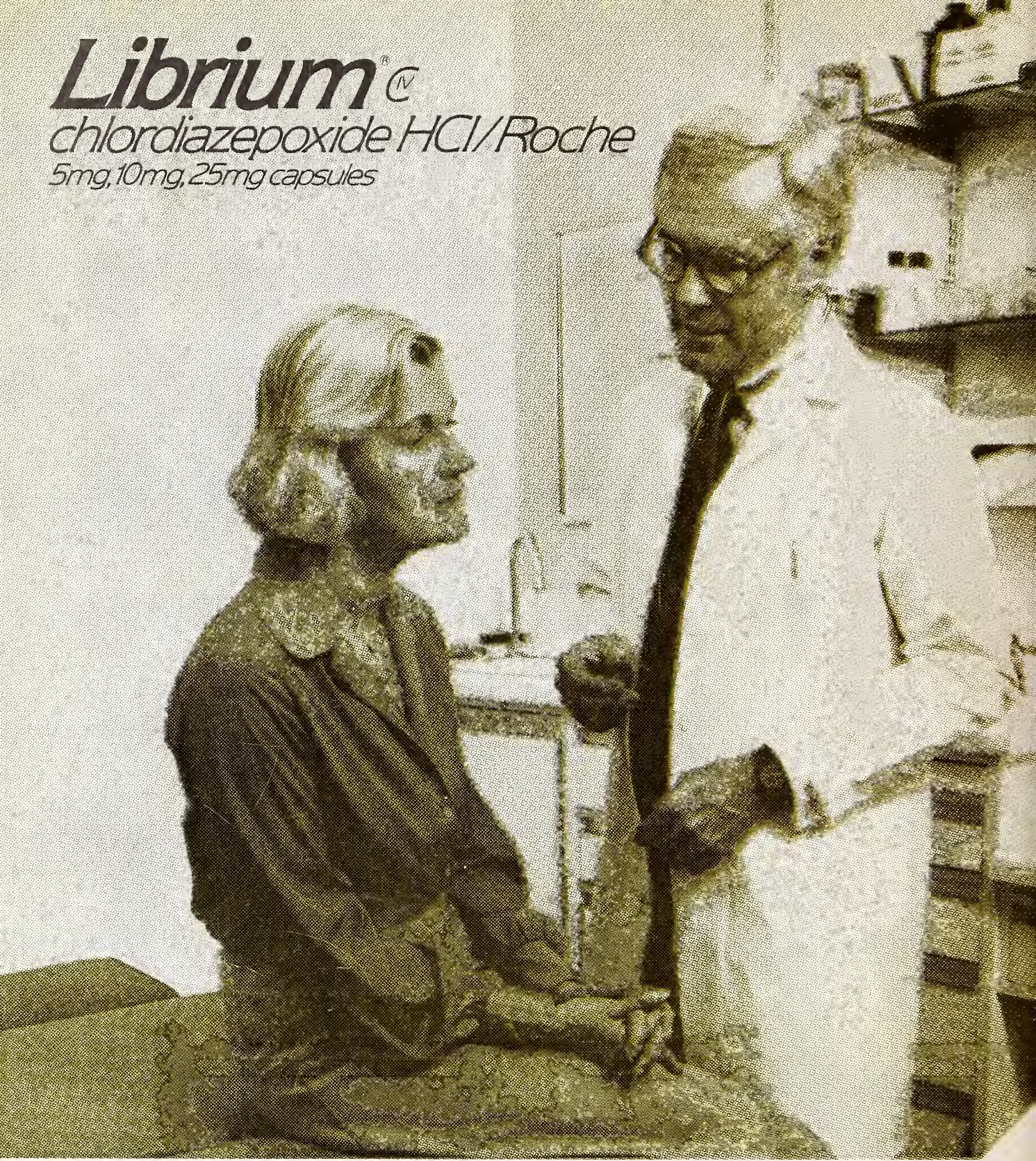
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Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

Volume 154, No. 5, November, 1978

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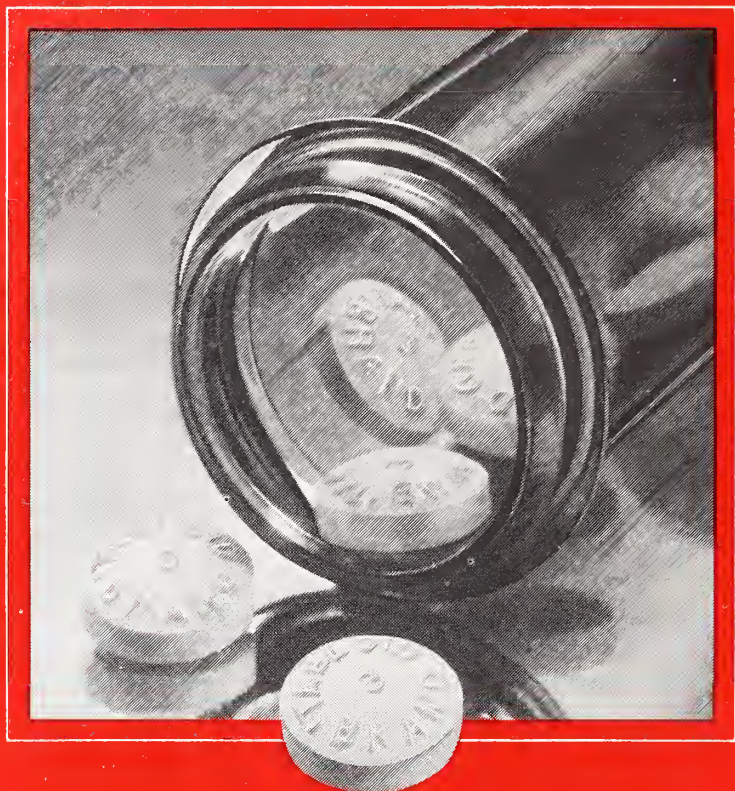
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Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malforma-

tions as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Obituaries

*Bordenave, Joseph L., Geneva, died September 29, 1978. Chairman of the ISMS Board of Trustees in 1975-76, Doctor Bordenave was active in many ISMS services and community activities. Doctor Bordenave, chairman of the Illinois State Medical Insurance Services Board of Directors from March, 1976 to April, 1978, was a past president of the Kane County Medical Society and also a past president of the medical staff at Community Hospital in Geneva. He had served as medical director for the Community Physicians Emergency Group.

**Carlstrom, Fred J., Rockford, died September 15, 1978 at the age of 88. Dr. Carlstrom was a 1926 graduate of St. Louis University. During his career he was an educator at St. Anthony's School of Nursing and was appointed head of the outpatient emergency services department at Swedish American Hospital.

*Crane, Thomas P., Dwight, died September 9, 1978 at the age of 72. Doctor Crane was former superintendent of the William W. Fox Developmental Center in Dwight.

*Czajkowski, Stephen, Chicago, died September 30, 1978.

*Friskey, Roger W., Evanston, died September 12, 1978 at the age of 54. Dr. Friskey was a 1950 graduate of Northwestern University, where he served as an associate professor of medicine. He was also an assistant medical director for Standard Oil of Indiana.

**Lyons, Mary M., Highland Park, died September 8, 1978. Dr. Lyons was a 1913 graduate of Bennett Medical College.

*Martens, Edward J., Elgin, died September 30, 1978. Dr. Martens was a 1942 graduate of the Chicago Medical School.

*Muraskas, Edward B., Oak Lawn, died September 30, 1978 at the age of 57. Dr. Muraskas was a 1945 graduate of Loyola University Stritch School of Medicine.

*Odegard, John Arden, Elmhurst, died September 29, 1978 at the age of 57. Dr. Odegard was a 1945 graduate of Northwestern University who served on the staff of Memorial Hospital of Dupage County for 28 years. Prior to his death he served on the staff of Passavant and Cook County Hospitals and was associated with the Chicago Medical School.

**Pomrenze, Herman M., Chicago, died October 6, 1978. Dr. Pomrenze was a 1918 graduate of Loyola University Stritch School of Medicine.

*Ortiz, Rafael, Chicago, died February 4, 1978. Dr. Ortiz was a 1960 graduate of University of Havana.

*Swastek, Edward J., Chicago, died September 17, 1978 at the age of 71. Dr. Swastek was a 1933 graduate of Loyola University Stritch School of Medicine.

*Tamas, Marie P., Chicago, died October 1, 1978 at the age of 76. Dr. Tamas was a 1930 graduate of the Medical School of Wien Austria.

*Indicates ISMS member.

**Indicates member of the ISMS Fifty Year Club.

Clinics for Crippled Children Listed for December

Thirty-three clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-two general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be nine special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

December	1	Division Cardiac—U. of I. at the Medical Center
December	5	Park Ridge Cardiac—Lutheran Gen. Hosp.
December	6	Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
December	6	Hinsdale—Hinsdale Sanitarium
December	7	Effingham—St. Anthony Mem. Hospital
December	7	West Frankfort—Union Hospital
December	7	Litchfield—St. Francis Hospital
December	7	Sterling—Community General Hospital
December	7	Lake County Cardiac—Victory Mem. Hosp.
December	8	Chicago Heights Cardiac—St. James Hosp.
December	11	Peoria Cardiac—St. Francis Hospital
December	12	Peoria—St. Francis Hospital
December	12	East St. Louis—Christian Welfare Hosp.
December	13	Carmi—Carmi Township Hospital
December	13	Rockford—St. Anthony's Hospital
December	13	Springfield Ped-Neuro—St. John's Hosp.
December	13	Champaign—McKinley Hospital
December	13	Joliet—St. Joseph's Hospital
December	13	Aurora—St. Joseph Mercy Hospital
December	14	Springfield—St. John's Hospital
December	14	Kankakee General—St. Mary's Hospital
December	15	Evanston—St. Francis Hospital
December	15	Kankakee Cardiac—St. Mary's Hospital
December	15	Chicago Heights Cardiac—St. James Hospital
December	18	Peoria Cardiac—St. Francis Hospital
December	18	Maywood—Loyola Medical Center
December	19	Peoria—St. Francis Hospital
December	19	Rock Island—Moline Public Hospital
December	19	Belleville—St. Elizabeth's Hospital
December	20	Chicago Heights Gen.—St. James Hosp.
December	21	Rockford—Rockford Memorial Hospital
December	21	Bloomington—Mennonite Hospital
December	21	Elmhurst Cardiac—Memorial Hospital of DuPage County

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



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CONTRAINDICATIONS Use in Newborn or Premature infants. This drug should not be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally and for newborns and premature infants in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma; increased intraocular pressure; hyperthyroidism; cardiovascular disease; hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined:

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils; flushing; and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and $\frac{1}{2}$ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977

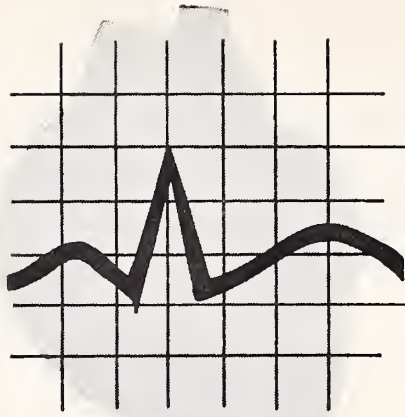
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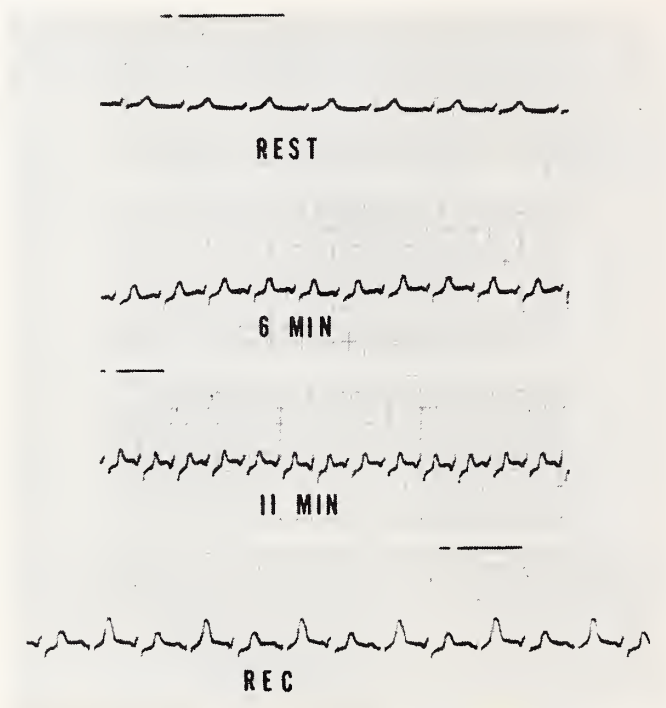
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ekg of the month

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PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

A forty-five year old man presented to his physicians for a routine examination. He planned to begin a jogging program to improve his physical work capacity. He physical examination was normal and he had no present or past history of serious disease. A resting ECG was interpreted as abnormal. His physician ordered a multistage exercise test by the method of Dr. Robert Bruce. The ECG rhythm strips shown are selections from the rest period, six minutes of exercise, eleven minutes of exercise, and early recovery (REC). The patient's total duration of exercise was eleven minutes, twenty seconds, and he stopped because his legs became tired.



Questions:

1. The strips from the exercise test show:

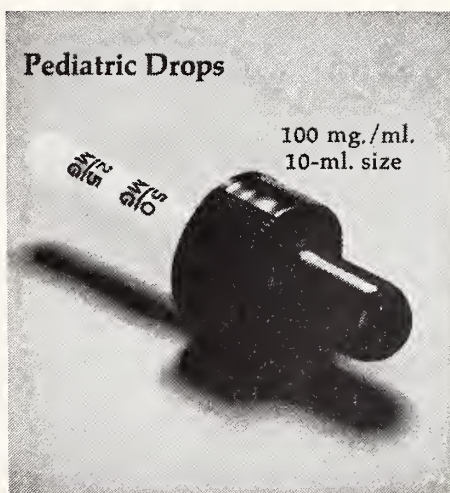
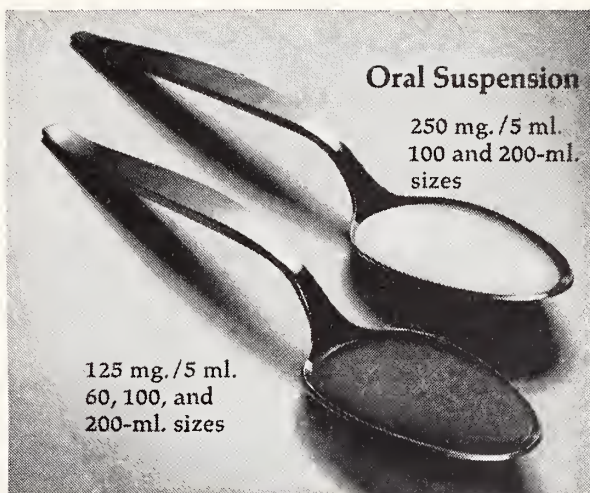
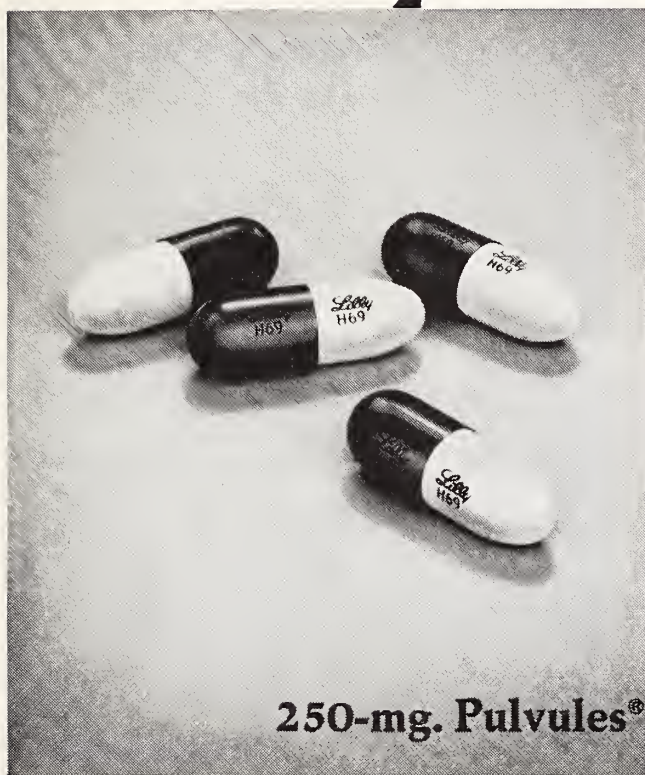
- Abnormal ST segment depression.
- A maximal heart rate of 130 beats per minute.
- Premature ventricular beats in bigeminy.
- An exercise induced intraventricular conduction defect.
- All of the above.

2. Management of this patient should include:

- Quinidine or Procainamide in appropriate doses.
- Propranolol and nitrates in appropriate doses.
- Consideration of coronary arteriography.
- Limitation of his activities, particularly vigorous jogging.
- None of the above.

(Continued on page 386)

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SBS PRESENTS

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Program

THE ACUTE CARE OF ALCOHOL WITHDRAWAL

James West, M.D., F.A.C.S., Chairman of ISMS Committee on Alcoholism and Drug Dependence, Assistant Professor of Psychiatry at Rush-Presbyterian St. Luke's School of Medicine will discuss the diagnosis and treatment of the acute alcoholic state and the subsequent four withdrawal stages.

THE FETAL ALCOHOL SYNDROME

Donald Wayne Sellers, M.D., Director of Psychiatric Services of the Alcoholism Treatment Center at Lutheran General Hospital, and Assistant Professor of Psychiatry at Abraham Lincoln School of Medicine, will discuss the characteristic features of the child with the fetal alcohol syndrome. He will present recent data regarding the etiology of the syndrome, some of which implicates mild social drinking as a causative factor.

UNDER-EIGHTEEN DRINKING

Donald MacLean, M.D., Assistant Professor of Psychiatry at the Rockford School of Medicine and practicing private psychiatrist will discuss the special social problems of under-18 drinking, as well as its legal implications. He will also discuss the implications of early drinking on future alcohol abuse.

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REPORT

FOR *Illinois Physicians*

Health Leadership Action Program

The Chicago-based Blue Cross and Blue Shield Plan's Health Leadership Action Program—a first in the nation—is serving as a model for dozens of other corporations and health care Plans.

The goal of the HLAP is to involve community leaders in dealing with major health issues of quality, accessibility and cost containment. The program is enjoying the support throughout Illinois of business, labor, consumer, government, fraternal, educational and health organizations.

The program is built on the concept that major health care issues can best be addressed at the local level. It recognizes that needs and concerns may differ in various areas of the state.

HLAP is designed to encourage local involvement to the maximum extent, with Blue Cross and Blue Shield serving as the catalyst, resource center and coordinator.

During the year, the Health Leadership Action Program has implemented a wide range of projects, including the following:

Action Councils. Two local action councils were formed—one downstate and one in the Chicago suburbs. Additional councils will be formed in 1979.

West Side Program. A massive screening-immunization project was conducted on Chicago's West Side, serving 12,000 people in that section of the city.

Symposium. A major symposium was held in 1977 featuring national authorities who gave their views on the nation's health care system. The 1978 symposium, "Private Initiatives in Health Care" was held November 15 in Chicago.

Seminars. Quarterly seminars were held at which nationally known speakers addressed select groups of community leaders from throughout Illinois on topics of importance in the health care field.

Educators Conference. A conference was held for Cook County school administrators and health educators on preventive health education for school children.

Speech Tournament. The Land of Lincoln Speech Tournament was cosponsored with Rock Valley College. College and university students spoke on the theme of lifestyle.

Health Fair. In conjunction with the University of Illinois at Urbana, a two-day health fair was held on campus. A wide variety of health educational material was distributed.

Lifestyle. Several events, including an exercise day and canoe race were held by the Plan to emphasize the need for exercise as an integral part of

good health habits.

At the heart of the Health Leadership Action Program are the action councils. The first council was formed in the fall of 1977 in a 17-county area of west-central Illinois; the second was formed in the spring of 1978 in Chicago's west suburban area.

Each council focused initially on health screening and awareness programs. Both councils conducted hypertension screening by using Blue Cross and Blue Shield's Mobile Information Centers—specially equipped mobile vans that take the programs to members' workplaces.

In addition to the screening, participants received health literature. One publication, "Your Lifestyle Profile" is a self-administered test that allows an individual to help determine his or her lifestyle condition—excellent, good, risky or hazardous.

Another pamphlet, "Change Your Mind About Your Body," addresses key lifestyle issues, such as stress, alcohol and smoking. It tells of the dangers and explains how a person can begin correcting problems and where help can be obtained.

- More than 5,000 persons were screened for hypertension since the West-Central Health Leadership Action Council was formed in Springfield in the fall of 1977.

The initial screening found that about 15 percent of the participants had elevated blood pressure that required medical attention.

- Twenty-two members of the Chicago West Suburban Health Leadership Action Council took part in its initial health screening program. Over 4,000 persons were screened for hypertension and 22,000 pieces of health literature were distributed.

- For the Chicago West Side Program, city agencies agreed to provide the necessary manpower (outreach workers, physicians, nurses and medical assistants) to perform various health tests and immunizations, and to inform the community on the program. Blue Cross and Blue Shield arranged for vans and provided clerical assistance.

Tests were conducted for lead poisoning, sickle cell anemia, hypertension, nutritional anemia, venereal disease and cervical cancer. In addition, 8,500 immunizations were given. This phase of the program was especially timely and significant because of the low level of immunizations of West Side school children.

Because of the success of the program, the Chicago Board of Health has urged Blue Cross and Blue Shield to continue the program in 1979 to areas of the city considered to be medically underserved.

HCFA Second Opinion Surgery Program

The Department of Health, Education and Welfare has drafted the following letter for use as a newsletter regarding their second opinion surgery program:

"Health Care Service Corporation (Blue Cross-Blue Shield) is part of a nationwide program providing second opinions for elective surgery and other major medical procedures. The program is being administered by the Department of Health, Education and Welfare through its Health Care Financing Administration (HCFA). Through its Regional Office in Chicago, HCFA has designated HCSC as list holder for Cook County.

We have recently contacted physicians in this area and requested that they participate in the second opinion program. Our role as list holder will be to provide names of participating physicians to individuals calling us to request a second opinion. In addition to Medicare beneficiaries, the HEW program will cover Medicaid recipients and members of the general public.

HCSC will receive calls from individuals wanting a second opinion at 661-4252. HCSC will not call the physicians to set up an appointment for a second opinion but will simply furnish the names. More than one name will be furnished whenever possible."

A brochure has been published by HEW entitled "Facing Surgery? Why Not Get A Second Opinion?" The following topics are discussed:

Second opinions make good medical services.

When you should get a second opinion.

Know the benefits, risks and alternatives to surgery.

How to find a specialist.

How to get a second opinion.

How to pay for the second opinion.

Often asked questions.

A final word about what second opinions are and what they are not.

Copies of this brochure may be obtained by calling the Regional Office of HEW at 353-4240.

Changes in Participation and Certification of Laboratory Procedures

Notices were received from the Medicare Bureau of the following changes in participation or in the certification of tests and procedures of laboratories in the Medicare program:

Cytotoxic Food Tests and Other Diagnostic Allergy Procedures
(Effective for Procedures Performed on and After August 1, 1978.)

Cytotoxic food tests, provocative testing, neutralization injections, intracutaneous titration, sublingual desensitization and leucocytotoxic testing are all tests employed to verify food allergies. HEW has been informed by their medical consultants that there is a lack of acceptable scientific information on the effectiveness and validity of these allergy procedures. Moreover, support of these tests by official groups of allergists has not been found.

Accordingly, cytotoxic food tests, provocative testing, neutralization injections, intracutaneous titration, sublingual desensitization and leucocytotoxic testing cannot be considered to be reasonable and necessary under Medicare law.

No program payment may be made for these allergy procedures performed on or after August 1, 1978.

Changes in Approved Tests and Procedures:

Island Medical Laboratory, Inc., 8452 Stony Island Ave., Chicago, Ill. 60617 (Provider Number 14-8247) has been approved to perform Procedures 300-Chemistry and 710-EKG Services, effective August 8, 1978. The laboratory is also approved to perform Procedures 110-Bacteriology; 200-Serology; 510-Blood Group and Rh Typing; 630-Diagnostic Cytology; and 400-Hematology.

Advanced Medical Laboratories, Inc., 5457 West Chicago Ave., Chicago, Ill. 60651 (Provider Number 14-8325) is no longer approved to perform Procedure 630-Diagnostic Cytology, effective October 1, 1978. The laboratory is approved to perform Procedures 110-Bacteriology; 200-Serology; 310-Chemistry Routine; 320-Clinical Microscopy; 400-Hematology; 510-Blood Group and Rh Typing.

Closing:

Medical Associates of Chicago, 3223 South Dr. Martin Luther King Jr. Drive, Chicago, Ill. 60616 (Provider Number 14-8080) has withdrawn from the Medicare program as an independent laboratory, effective September 1, 1978. No payment will be made by Medicare for services furnished to patients on or after that date.

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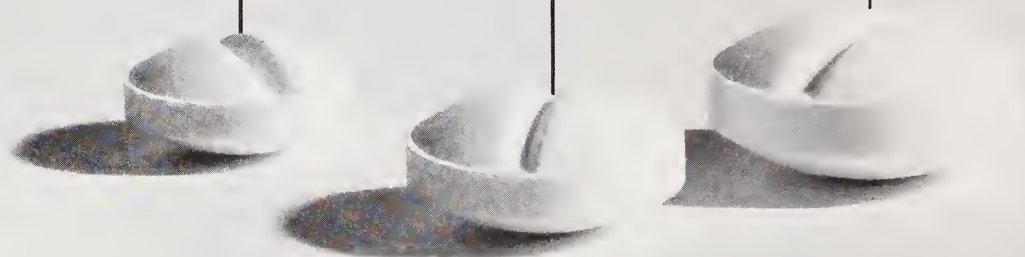
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Penicillin Responsiveness As An Aid In Differential Diagnosis

Disseminated Gonococcal Infection

BY EUGENE B. LOFTIN, III, M.D., KENNETH P. CRANE, M.D.,
AND WILLIAM J. ARNOLD, M.D./CHICAGO

Hematologically-disseminated gonococcal infection (DGI) is usually described as an acute, migratory, non-destructive polyarthritides-tenosynovitis associated with skin lesions and typically occurring in young females. Our retrospective study of fourteen patients with DGI syndrome confirms this impression. However, our study also suggests that DGI syndrome may occur frequently in males (5/14 cases) and that typical skin lesions or positive cultures for gonococcus are frequently absent (8/14), which complicates the differential diagnosis. In the latter setting our analysis indicates that following a thorough evaluation, a therapeutic trial of penicillin will always result in significant improvement after 48-96 hours in patients with the DGI syndrome and therefore, frequently supplies the correct diagnosis.

The incidence of human infection with *Neisseria gonorrhea* has shown a striking increase in the United States since 1919.¹ This has been accompanied by a wider recognition of hematologically-disseminated gonococcal infection (DGI) which is manifest as an arthritis-dermatitis syndrome. This DGI syndrome was first described by Vidal in 1893 as a monoarticular destructive arthritis associated with skin lesions seen primarily in males.² Although initially thought to be an unusual accompaniment of *N. gonorrhea* infection, the DGI syndrome is estimated to occur in 1-3% of patients.³ Additionally, the DGI syndrome is now characterized as a non-destructive

poly- or monoarticular arthritis associated with fever, chills, pharyngitis, and skin lesions.⁴⁻⁶

Skin lesions may vary in appearance from small, erythematous, non-tender macular lesions to painful, pustular lesions often with a necrotic center.^{4,7} DGI diagnosis is often delayed because these clinical findings frequently occur in the absence of the classic signs and symptoms of genitourinary infection. In addition, arriving at the correct diagnosis is complicated by poor recovery of the gonococcus from synovial fluid and blood cultures. Although less than satisfactory, Garcia-Kutzbach and co-workers have suggested that a prompt response to penicillin therapy may be used retrospectively

to establish the diagnosis of DGI.⁸ Using this criteria we have reviewed the clinical characteristics of 14 patients with a penicillin-responsive arthritis-dermatitis syndrome seen by the rheumatology service between 1975 and 1977. Our analysis indicates that DGI may occur in both males and females and is often the presenting manifestation of *N. gonorrhea* infection. In addition, our experience suggests that the diagnosis of DGI is often made on a clinical rather than a laboratory basis and that penicillin responsiveness is a valuable clinical criterion.

Materials and Methods

Fourteen patients seen by the rheumatology service at the University of Illinois and West Side Veterans Administration Hospital from 1975 to 1977 were studied by chart review. Synovial aspirate, pharynx, urethra, cervix, blood and rectum were sampled and plated at bedside on Thayer-Martin and chocolate agar plates which were then held in a candle jar. Not all suggested sites were cultured in all cases, but the majority of case evaluations included at least cultures of synovial aspirate, blood, and urethra.

On the basis of the clinical manifestations and culture results the patients were then divided into the groups suggested by Gelfand and co-workers⁹ (Table I).

Results

The typical presentation involved a young patient who was sexually active with multiple partners. These patients all sought medical assistance for pain and swelling in multiple joints. The age range for females was 17 to 42 years with a mean age of 28 years, and for males 19 to 48 years with a mean age of 32 years. None of these patients presented with a chief complaint of venereal infection. Six of 14 patients had a history of previous gonococcal infection. Five of 14 patients were married. Typical history prior to admission was a prodrome of fever often with chills (7 cases) and/or pharyngitis (4 cases) lasting 1-4 days prior to the onset of swollen painful joints. These usually included wrists (usually dorsum), metacarpophalangeal joints, ankles and knees, but occasionally also the elbows and shoulders.

The typical skin lesions were not usually mentioned by the patients but were noted on physical examination in 10 cases. All patients presented with low grade fever ranging from 99° to 103°F.⁴ Physical examination also showed urethral, or vaginal discharge, or cervicitis, in 2 of

9 cases with negative synovial fluid cultures (Group Ib). The same problems were evident in the one case with positive synovial fluid culture (Group III), and 1 of 3 suspected cases (Group IV).

Of the cases where *N. gonorrhea* was cultured, one was from the urethra and another from the vagina (Group Ib). In addition, gram negative diplococci were seen in white cells in the synovial fluid in one case (Group Ib), but could not be cultured. In patients with positive synovial fluid cultures (Groups II and IIIa) for *N. gonorrhea*, the organism was not cultured from other sites. No positive cultures were obtained by definition in Group IV but gram negative intracellular diplococci were observed in the vaginal smear of one patient. No joint that was X-rayed in any case showed abnormality. Synovial fluid aspirates had WBC counts ranging from 14,000/mm³ to too numerous to count (>100,000/mm³).

The common denominator in all patients was the remarkable response to penicillin therapy. Typically, patients became afebrile within 24 hours after beginning penicillin therapy. Subjective and objective improvement of the articular manifestations was evident by 48 hours with marked improvement by 5 days (mean 66 hours). No new skin lesions were noted to occur after 24 hours on penicillin therapy.

Discussion

This study supports the modern picture of DGI syndrome as an illness primarily of young, otherwise healthy individuals. In nine of our fourteen patients the DGI syndrome was characterized by an acute febrile illness associated with characteristic skin lesions and polyarthritis-tenosynovitis. This study does not support the previously reported high incidence of monoarticular disease.⁴⁻⁶ Although there is no obvious reason for this discrepancy, it may be due to the organism's progressive changing character or early presentation for therapy.^{9,10} In addition, this study demonstrates that the DGI syndrome is not only a disease of females but frequently involves males. Even though the population of males was primarily from the West Side Veterans Hospital, the sizeable number should still remind the clinician that this syndrome does occur in males.

The variable clinical manifestations of DGI syndrome with the frequent absence of genitourinary symptoms in our study stresses the importance of the recognition of the DGI syndrome as the initial presentation of gonococcal infection to the internist, family physician, or dermatol-

Table I
Clinical Classifications of 14 Patients
With the DGI Syndrome

Patient Groups*	Ia	Ib	II	IIIa	IIIb	IV
# of Patients	None	9	1	1	None	3
Sex	—	4F/5M	1M	1F	—	3F
Marital Status	—	2 married 7 other	1 single	1 single	—	3 married
History of Previous G.C.	—	4/9	—	1/1	—	1/3
History of Discharge	—	1/9	—	1/1	—	1/3
History of Pharyngitis	—	2/9	—	—	—	2/3
Positive Cultures For N. Gonorrhea	—	2/9	1	1	—	0/3
Time to Response After Start of Antibiotic	—	1-4 days (mean 66 hr)	5 days	48 hrs	—	2-4 days (mean 72 hr)

***Group I—Hematogenous**

No cultural confirmation of gonorrhea from synovial fluid, type:

- a. Positive blood cultures for N. gonorrhea
- b. Typical skin lesions of gonococcal sepsis, but negative blood cultures.

Group II—Transition

Positive cultures for N. gonorrhea from synovial fluid plus positive blood cultures or typical skin lesions.

Group III—Joint Localization

Positive synovial fluid cultures for N. gonorrhea.

No skin lesions or positive blood cultures, type:

- a. Polyarthrititis,
- b. Monoarthrititis

Group IV—Suspected Cases

Suggestive clinical pattern including history, physical and X-rays.

No skin lesions or positive blood cultures.

No cultural confirmation from synovial fluid.

ogist. The differential diagnosis of this presentation is broad and includes (Table II):

1) *Other causes of infectious arthritis* should be easily differentiated by age and previous health history of patient, by blood and synovial fluid cultures, and by response to specific therapy.¹¹

2) *Acute rheumatic fever* has its own characteristic rash and may be associated with myocarditis. The arthritis of acute rheumatic fever does not respond to penicillin therapy.

3) *Reiter's syndrome* is predominantly a disease of males with characteristic ocular and painless mucous membrane lesions.

4) *Immune complex disease* associated with systemic lupus erythematosus and hepatitis-associated antigen should be considered. The typical rash of DGI is absent in both. SLE may have

other signs suggestive of the diagnosis and the fluorescent test for antinuclear antibodies is positive. HAA polyarthrititis may closely mimic the DGI syndrome, however, the finding of antigenemia and abnormal liver enzymes readily distinguishes between the two illnesses.

5) *Henoch-Schölein purpura* is a disease primarily of children with non-pustular lesions which are more widely distributed than those seen in N. gonorrhea and involve the face.

6) *Chronic meningococcal septicemia* may clinically be identical to the DGI syndrome particularly in milder cases. The lesions of meningococcal septicemia are rarely pustular and are more widely distributed than those of N. gonorrhea.

7) *Lymphogranuloma venereum* is also associated with arthralgia and fever, but the skin

Table II
Differential Diagnosis of DGI Syndrome

-
- | |
|--|
| 1) Other causes of infectious arthritis |
| 2) Acute rheumatic fever |
| 3) Reiter's syndrome |
| 4) Immune complex-mediated diseases |
| 5) Henoch Schönlein purpura |
| 6) Meningococcemia |
| 7) Lymphogranuloma venereum |
| 8) Lyme arthritis |
| 9) Type B. Hemophilus influenza arthritis |
| 10) Streptobacillus moniliformis arthritis |
-

lesions are not pustular and the syndrome is associated with typical adenopathy not found in DGI.

8) *Lyme arthritis* is a recently described clinical entity with symptoms of fatigue, chills, fever and pharyngitis associated with monoarticular or oligoarticular arthritis sometimes following the onset of a rash which begins on the extremities as a red macule or papule (erythema chronicum migrans).¹² The main points of differentiation from the DGI syndrome are that Lyme arthritis occurs primarily in eastern Connecticut with peak incidences in summer or early fall. Cases present in clusters and the rash progresses to large annular lesions.

9) *Type B. Hemophilus influenza arthritis* usually occurs in childhood.¹³ The infected synovial fluid is purulent and green-tinged. This has been described as characteristic of H. influenzal pyarthrosis.¹⁴ Most cases occur in patients with chronic debilitating disease.

10) *Streptobacillus moniliformis arthritis* has a skin rash which is morbilliform to rubella-like.¹³ No vaginal or penile discharge is present. The gram stain of synovial fluid reveals gram negative pleomorphic bacillus.

Treatment

An approach to the patient presenting with polyarthritis of abrupt onset in whom the differential diagnosis includes the DGI syndrome should include the following:

1) Careful history for length and distribution of symptoms and for any associated infections or complaints suggestive of gonorrhea. This includes a careful sexual and menstrual history.

2) Careful physical examination for the characteristic skin lesions of gonococcemia (or the other diseases in the differential diagnosis).

3) Cultures of throat, urethra, and rectum for N. gonorrhea (tenosynovitis may also be aspi-

rated but culture of skin lesions are usually non-productive in DGI).

4) X-rays of affected joints.

5) Aspiration of synovial fluid for culture, routine and polarizing microscopy, gram stain, and determination of total WBC count and differential and glucose (with a simultaneous serum glucose).

6) Routine laboratory studies including CBC, urinalysis, chest X-ray, EKG, erythrocyte sedimentation rate.

7) Special laboratory studies including liver function tests, ASO titer, antinuclear antibodies and hepatitis-associated antigen and antibodies.

Once the initial data base is gathered, then a trial with intravenous penicillin (10 million units per 24 hours) should be commenced if the exact diagnosis remains unclear.¹⁵ In our study, 90% of patients had some subjective response to penicillin within 48 hours. It is important, however, that no other agents such as analgesics or anti-inflammatory agents be given during this trial period in order not to confuse the response to antibiotics. Persistently inflamed joints should be aspirated dry once or twice daily until a response is obtained. If no response to penicillin is evident in four days, the diagnosis of the DGI syndrome is dubious and antibiotics may be discontinued (if cultures are negative).¹⁶ At this point a thorough re-evaluation should be performed and further therapy instituted on the basis of the new data.

Conclusion

The characteristics of the syndrome have changed, probably as a result of selective pressures from antibiotic usage and social conditions.¹⁰ This study supports the modern picture of the DGI syndrome as a febrile illness primarily of young females or males who present with polyarthritis and characteristic skin lesions. The arthritis is non-destructive and penicillin responsive. This study also illustrates the usefulness of penicillin responsiveness as a diagnostic criterion. ◀

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Screening For Alcoholism

BY LEE SPALT, M.D./CARBONDALE

Valid, brief screening procedures for alcoholism are needed to identify that drug dependency in patients. The diagnostic criteria for psychiatric research of Feighner, et al., were used to diagnose alcoholism in 37 (24%) of 154 consecutively evaluated psychiatric outpatients in a university medical center general psychiatry clinic. Data analysis demonstrated that the patients' reports that either they, their families, or other cardinal persons thought they drank too much alcohol did identify all (100%) of the alcoholics. The findings supported the earlier reports of Woodruff, et al.

A brief screening for alcoholism using patients' reports of excessive drinking was found to be a reliable indicator for the presence of alcoholism.

The most prevalent form of physical dependence is that produced by the drug alcohol.¹ Because of its frequency, chronicity, and social, psychological and medical complications, alcoholism is probably the single most important psychiatric public health problem in the United States.² Although many patients who have a history of alcoholism come to the attention of health care professionals, the alcoholism is not always recognized.³⁻⁶

Alcoholics Anonymous used a 36-item questionnaire for the study of certain symptoms of alcoholism. E. M. Jellinek published the findings in 1946.⁷ After more elaborate study using

a 111-item questionnaire, Jellinek presented new findings in 1952.⁸ Recent reports have presented more manageable diagnostic criteria^{6,9-11} outlined by Feighner, *et al.*¹² More recently Woodruff, *et al.*, published a brief screening method for identifying alcoholism.¹³ They found that 98% of patients with histories meeting research criteria for definite alcoholism and 89% of patients with probable alcoholism were identified by the subjects' reports that they or others believed the subjects drank too much. Woodruff, *et al.*, concluded that several easily administered questions could serve as a highly reliable screening test for alcoholism.

It is hypothesized that patients' reports that they or others thought that they (the patients) drank too much alcohol identify the presence of alcoholism as adequately as more extensive symptom histories.

Method

Comprehensive, structured interviews covering details of the Feighner, *et al.*, diagnostic criteria for psychiatric research were uniformly adminis-



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Table 1
Research Criteria for a Diagnosis of Alcoholism

Group A

1. Have you experienced withdrawal symptoms (shakes, convulsions, hallucinations, DT's) when you have stopped drinking alcohol?
2. Have you had medical complications (liver, stomach, pancreas, muscle or nerve problems) from drinking alcohol?
3. Have you experienced blackouts (periods of amnesia not related to head injury) when you have been drinking heavily?
4. Have you gone on drinking binges or benders (drinking for 48 or more hours with neglect of your usual duties)? More than one bender is needed to score as positive.

Group B

1. Have you been unable to stop when you wanted to stop drinking?
2. Have you attempted to control your drinking by allowing yourself to drink alcohol only under certain circumstances?
3. Have you drunk alcohol before breakfast?
4. Have you drunk non-beverage alcohol (hair oil, mouth wash, Sterno, etc) for its alcohol content?

Group C

1. Have you had arrests related to drinking alcohol?
2. Have you had traffic difficulties related to your use of alcohol?
3. Have you had trouble at work or school because of your drinking?
4. Have you had fights associated with times that you have been drinking?

Group D

1. Have you thought that you drink too much alcohol?
2. Has your family objected to the amount of alcohol you drink?
3. Have you lost friends because of your drinking?
4. Have persons other than your family objected to the amount of alcohol you drink?
5. Have you felt guilty about your drinking?

tered to each of the 154 patients seen for evaluation by this investigator during six consecutive months. The site was a public/semi-private psychiatric outpatient clinic attached to the Washington University School of Medicine and serving the metropolitan St. Louis, Missouri-Illinois area.

A diagnosis of definite alcoholism was made when symptoms were present in three of the four groups of symptoms outlined in Table 1. Probable alcoholism was diagnosed when symptoms were present in two of the four groups.

The study sample included both new and return patients from a variety of referral sources and was representative of the psychiatric clinic population. The significance of findings was tested by the chi-square and, when appropriate, also the Yates correction method.

Results, Data and Discussion

Table 2 presents the frequency of symptoms of alcoholism for the present study, compares symptom frequencies for both alcoholic and non-

alcoholic psychiatric patients, and compares findings of the present study with those of Woodruff, *et al.*¹³ Both the Woodruff, *et al.*, study and the present study used the Feighner, *et al.*, diagnostic criteria for psychiatric research to identify alcoholic patients. The present study found 37 (24%) alcoholic patients among 154 consecutively evaluated psychiatric outpatients. Woodruff, *et al.*, studied 500 probands and diagnosed 70 (14%) alcoholics.

Alcoholics interviewed in the present study more often reported attempted control (78% vs 31%) and inability to stop drinking (59% vs 36%) than in the previous study. The present study nonalcoholics also reported more attempted control (8% vs 1%) and inability to stop drinking (3% vs <1%) than the previous study nonalcoholics. Present study alcoholics less often reported that persons other than family objected to their drinking (35% vs 70%). Other symptom frequencies did not vary significantly between the two studies.

In the present study each symptom of alcoholism was reported significantly more often (at

Table 2
Frequency of Symptoms of Alcoholism

N Symptoms	Alcoholics				Nonalcoholics			
	Woodruff, <i>et al.</i>	P	Present Study	P	Present Study	P	Woodruff, <i>et al.</i>	
	(70) %		(37) %		(117) %		(430) %	
Group A.								
Withdrawal symptoms.	40	NS	49	<.0005	—	NS	—	
Medical complications		NA	22	<.0005	—	NA		
(Impotence)*	6	NA				NA	1	
Blackouts.	66	NS	57	<.0005	2	NS	2	
Binges or benders.	46	NS	54	<.0005	1	NS	—	
Group B.								
Unable to stop.	36	<.05	59	<.0005	3	<.005	—	
Attempted control.	31	<.0005	78	<.0005	8	<.0005	1	
Alcohol before breakfast.	61	NS	54	<.0005	2	NS	1	
Non-beverage alcohol.	4	NS	3	<.005	—	NS	—	
Group C.								
Alcohol related arrests.	34	NS	30	<.0005	2	<.01	—	
Traffic difficulties.	23	NS	41	<.0005	1	NS	2	
Trouble at work.	19	NS	24	<.0005	—	NS	1	
Fighting.	46	NS	57	<.0005	3	NS	2	
Group D.								
Pt. thinks drinks too much.	75	NS	81	<.0005	9	NS	7	
Family objects.	77	NS	78	<.0005	9	NS	7	
Loss of friends.	21	NS	32	<.0005	1	NS	—	
Others object.	70	<.001	35	<.0005	2	NS	3	
Pt. feels guilty.	53	NS	49	<.0005	3	NS	2	

*Woodruff, *et al.* reported the specific medical complication of impotence.

NS = Not Significant

NA = Not Applicable

least 8 times more often) by those patients diagnosed as alcoholic ($p < .005$). As Woodruff, *et al.*, indicated, the report of excessive drinking alone adequately identified the alcoholic patients. In the present study, the report of excessive drinking alone identified all the alcoholic patients. When Woodruff, *et al.*, used one of the three reports of excessive drinking as an indication of alcoholism, they found 9% to 11% of each non-alcoholic group were misidentified as alcoholic. In the present study a report of at least one of the three kinds of reports of excessive drinking was found in 15 (12.8%) of the nonalcoholic group. Of those 15 nonalcoholics misidentified by the three brief screening questions, 10 thought that they drank too much, 10 reported that their families objected to their drinking, and 2 indicated that other cardinal persons thought that the patients used too much alcohol.

We found the most frequently reported symptom of alcoholism to be that the patients thought themselves to drink too much alcohol (81%).

Table 3
Alcoholics Identified by Report of Excessive Drinking*

	Woodruff, <i>et al.</i>	Present Study
Probable Alcoholism	(N=19)	(N=1)
Excessive drinking reported	89%	100%
Excessive drinking not reported	11%	—
Definite Alcoholism	(N=51)	(N=36)
Excessive drinking reported	98%	100%
Excessive drinking not reported	2%	—
All Alcoholism (probable and definite combined)	(N=70)	(N=37)
Excessive drinking reported	96%	100%
Excessive drinking not reported	4%	—

*Excessive drinking was considered reported if the patient reported that the patient, a member of the patient's family, or some other cardinal person thought that the patient drank too much alcohol.

Family objection and patient attempted control were each reported by 78% of the alcoholic patients. A report of the objection of other cardinal

persons was recorded for only 35% of the alcoholic group, with eight other symptoms being reported more frequently.

Summary

Alcoholism was present in 24% of the 154 patients interviewed. The alcoholics reported symptoms of alcoholism in frequencies compatible with previous reports, with the exceptions of more attempted control, more inability to stop, and less objection by other cardinal persons.

All (100%) of the alcoholics were identified by their report that they, their family, or others thought they used alcohol to excess. A brief screening for alcoholism using patients' reports of excessive drinking was found to be a reliable indicator for the presence of alcoholism. ◀

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A More Physiologic Skin Prep

BY HUGH A. JOHNSON, M.D. AND LARRY D. EDWARDS, M.D./ROCKFORD

A series of 807 plastic surgical cases were operated using a surgical prep of physiologic solution only. In one case a lip incision became infected with the same organism cultured from a chalazion present at the time. In four cases there was drainage either from too tight sutures or following excision of ulcerating epitheliomas. This gave an over-all infection rate of 0.62%.

Homeostasis (a tendency to stability in the normal body state of an organism) is a word seldom used today. It serves well to describe the symbiotic relationship we have with bacteria. In truth, we cannot live in health without our bacteria. The use of prophylactic antibiotics and their sometimes disastrous upsetting of homeostasis emphasizes this relationship. If we use strong chemicals in our surgical prep we must upset the homeostasis of our skin flora and leave the way open for the ill effects of an imbalance just as do "prophylactic antibiotics." It is essential to become aware of the reproductive needs of pathogenic organisms: their presence in significant numbers to propagate, a medium conducive to growth in large number, and a lowering of

the host's defences.

The usual "thorough" surgical prep provides two of these three requirements, dead cells as the residue of strong chemicals, (soap, etc.) and traumatized tissue even the gentlest surgeon must leave behind. The hospital environment often provides the third—a significant number of pathogens to reproduce. All the requirements are fulfilled: natural skin resistance is destroyed by scrubbing and chemicals, the medium of dead cells is present and pathogens are introduced.

An Example

A plastic and reconstructive surgeon who attempts to sterilize the face will occasionally get soap in a patient's eye. Such accidents illustrate what must be the disastrous effect on naked, exposed cells which are damaged even by air. Bacteriologists are aware that attempts to "sterilize" skin are ridiculous.

Logic suggested an attempt to perform facial surgery on out-patients (who don't come to the operating room drenched in nosocomial organisms) without a surgical prep. The face was gently wiped with a soft gauze sponge soaked in a physiologic solution (preferably Physiosol, Abbott Laboratories brand, a perfectly formulated irrigating solution but physiologic saline if unavailable) as a sop to the nurses' penchant for the antiquated antiseptic era. Admittedly, the experiment was approached with some trepidation. It is hard to overcome with reason the superstitions of a lifetime, and "malpractice" clouds one's thinking.

Results

As the number of facial cases done without

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1+ STREP NOT GRP D		
SENSITIVE	MODERATELY SENS	STREP NOT GRP D
PENICILLIN		RESISTANT
Oxacillin		TETRACYCLINE
CLINDAMYCIN		KANAMYCIN
ERYTHROMYCIN		GENTAMICIN
VANCOMYCIN		
CHLORAMPHENICOL		
CEPHALOTHIN		
AMPICILLIN		
TEST COMPLETE		

Figure 1
Cultures of the infected case. The same organism for the sty and the infected wedge resection.

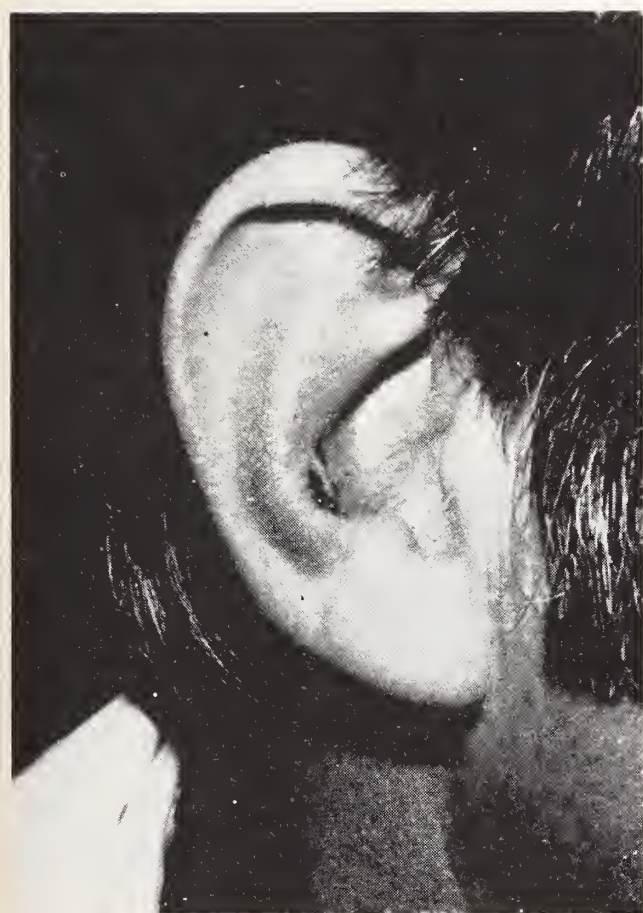


Figure 3
Draining epithelioma

infection increased, the method was attempted on theoretically more susceptible cases. It soon became obvious that logic applies to the rest of the body as well as the face. The prep has now been applied without infection to very susceptible cases. Even breast implants (the introduction of a foreign body, another factor) and abdominoplasty, dangerous because of the handling of a large amount of relatively avascular fat, have been completed successfully. A total of



Figure 2
Sutures too tight—an alar base excision with slough and drainage.

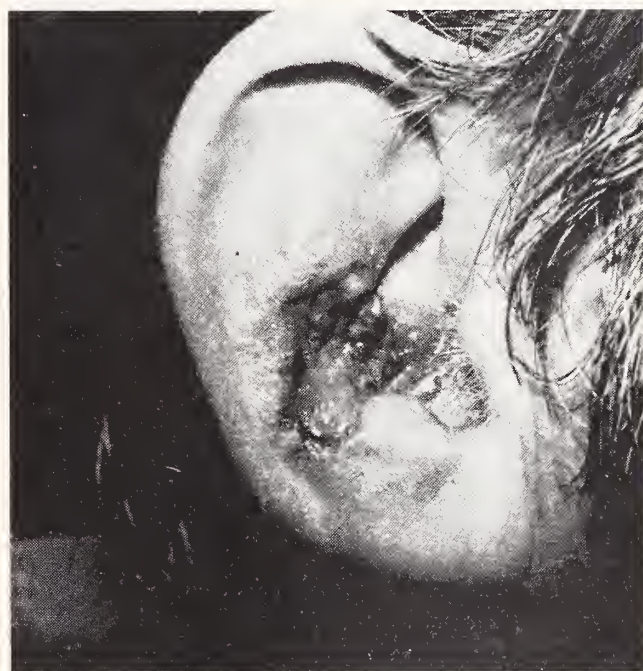


Figure 4
Stent was too tight, produced slough at skin edges with drainage.

807 operations using only a wipe with a physiologic solution on all areas of the body, including hands, can be reported. Only one true wound infection has resulted, a patient with a chalazion, on whom a wedge resection of an epithelioma of the lip became infected. The organism was the same from both lesions (Figure 1).

In three cases, faulty technique, too tight a wound closure, caused local slough, but not a true wound infection (Figures 2, 3, 4, 5 and 6).

One case, a longstanding recurrent and ulcerated epithelioma with bone exposed and con-



Figure 5
Healed without loss of graft



Figure 7
Post-operative recurrent epithelioma with bone exposed.



Figure 6
Too tight closure of wedge resection of ear with drainage.



Figure 8
Wound contaminated—but healed without loss of graft.

tamination before surgery remained contaminated throughout the healing phase, but healed without loss of skin graft (Figures 7 and 8). Counting all of these as infections gives a rate of 0.62%.

Discussion

Several variables may have affected the present retrospective experiment. Every attempt was made to be a gentle surgeon. Tissue was viewed in terms of the surgeon's own eye—would you want someone to pick up your unanaesthetized conjunctiva with a large toothed forceps, or crushed by a haemostat, however small? Patients were admitted on the morning of surgery, which was performed in the afternoon and as many as possible were dismissed the next morning. As many as possible were out-patients which eliminated the nosocomial element.

A controlled series with quantitative bacterial cultures should be initiated to ascertain the effect of germicide versus physiologic preparation of the skin.

This can be accomplished by using two sites in the same patient (e.g. bilateral procedures on

both ears, both breasts). One site could be prepared with a standard surgical scrub and the other site with physiologic saline. Quantitative bacterial cultures would be done before and after the prep and before closing the surgical wound. This study should be done on patients who are likely to have normal skin flora, i.e. not patients that have been exposed to the hospital's abnormal bacterial flora for a protracted period before surgery. Elective plastic surgery patients should be ideal.

Suture material could be considered foreign bodies as far as tissue reponse goes. A comparable series of cases using soap or other chemical surgical prep should be done. This would eliminate the variable of gentle surgeon vs. rough surgeon.

To meet this need, a local veterinary surgeon (also interested in the ideal prep) plans to supervise an experiment on cats brought to him for disposal. This will be single blind: the surgeon and veterinarian will do the prep but the bacteriologist alone will know into which surgical wound a significant number of pathogenic bacteria have been introduced. These findings should be contributory in resolving our questions about a physiologic skin prep for surgery. ◀

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Case Report

Sudden Paraplegia Caused By An Intraspinal Schwannoma

BY JAMES B. MANSFIELD, M.D./ELGIN

Intraspinal schwannomas most often arise from the posterior roots and present with either subacute or chronic symptomatology. An unusual case of paraplegia caused by hemorrhage within a schwannoma located anterior to the thoracic spinal cord is presented herein. To the author's knowledge, this is the first case reported in the literature.

A 75-year-old white man was admitted to the hospital because of upper abdominal and low chest pain. It had been present for two to three weeks, was intermittent, and seemed to either radiate from the back anteriorly or vice versa. He had noted some constipation, but denied any urinary difficulties. Somewhat over four years previously an adenocarcinoma of the right colon was treated with a radical hemicolectomy. His postoperative course had been satisfactory and he had a weight increase of 25 lbs. He was known to have a positive serology which had been treated twice in the distant past with un-

known medications. There was a rather vague history of somewhat progressive but intermittent weakness of the right leg for some five years.

While undergoing work-up of his pain, a spinal tap was performed. Analysis yielded a white cell count of 14, 80% of these seg-

mented neutrophils and 20% lymphocytes, a total protein of 440 mg.% with a gamma globulin of 11%, and a VDRL positive to 2 dilutions. No measurement of spinal fluid dynamics was made. His only other significant laboratory abnormality was a serum RPR positive to 64 dilutions.



JAMES B. MANSFIELD, M.D., is a board certified neurosurgeon who is an attending physician at Sherman and St. Joseph Hospitals in Elgin. Doctor Mansfield is also a clinical associate at the UI Abraham Lincoln School of Medicine in Chicago.

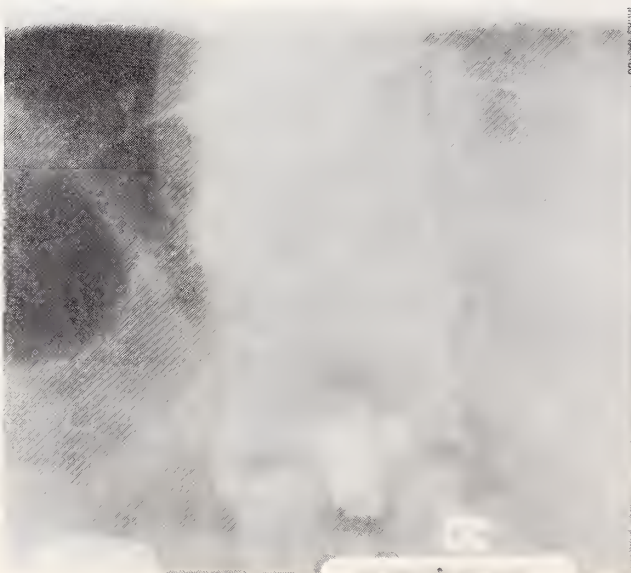


Figure 1
Pantopaque myelogram with patient in head down position shows complete block at the lower level of T12.



Figure 2

Compactly arranged spindle cells with long oval nuclei are evident. Vascular congestion and hemorrhagic features are also seen. (H & E times 100)

Two days later he was in the X-ray department having a barium enema performed when he suddenly lost strength and sensation in his legs. At this time, neurosurgical consultation was obtained. Abnormalities were limited to the lower extremities. Except for a bit of right hip extension, he was totally paraplegic. Deep tendon reflexes were absent in the legs without plantar response. There was no position and vibratory sensation in the lower extremities, and a sensory level to pinprick was present at about T11-12. Dexamethasone was begun.

Plain films of the thoracic spine showed no evidence of paraspinal mass or erosion of the bony structures. Spinal tap at the L4 interspace revealed blood tinged fluid with no increase in pressure in response to bilateral jugular venous compression or Valsalva maneuver. One cc. of pantopaque was inject-

ed and complete block was noted at the T12 level (Fig. 1).

An emergency thoracolumbar laminectomy was performed. No evidence of bony erosion or epidural tumor was found; however, palpation of the dural sac revealed an abnormally firm segment approximately 3 cm. in length. After opening the dura, the spinal cord appeared to be somewhat thinned out. No intramedullary tumor was visible, but slight retraction of the cord revealed a reddish-black ventral mass. This was attached to an anterior nerve root which was clipped and the 4x2x1.5 cm. nodular tumor was removed. Microscopic examination revealed this to be a schwannoma with vascular congestion and hemorrhagic features (Fig. 2).

The patient had no return of motor function in his legs post-operatively. Position sense returned to a moderately diminished

state and the vibratory sensation to a markedly diminished one. He could differentiate sharp from dull in his legs, but a sensory level was still obtainable at about the L1 level. Steroids were gradually discontinued and he was discharged to a rehabilitation facility.

Discussion

According to Russell and Rubinstein, intraspinal schwannomas arise almost invariably from the posterior roots.^{1,3} Occasional involvement of motor roots has been recorded in the European, as opposed to English, literature; however, no case that presented with the precipitous onset of paraplegia has previously been noted.²

Selective involvement of the posterior roots accounts for the high incidence of radicular pain as a first symptom of the tumor. This patient's vague history of right leg weakness may have been indicative of pressure on the ventral cord from the slowly growing tumor. Hemorrhage within the tumor with consequent sudden enlargement of the mass and pressure upon the already compromised spinal cord is postulated as causing the sudden onset of paraplegia. Limited recovery of function was confined to the posterior columns, which was the area of spinal cord most distant from the insult. This case is presented because of its rarity and because it occurred in a setting thought preoperatively to be most compatible with metastatic tumor to the spine.

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Factitial Panniculitis

BY VALEE HARISDANGKUL, M.D., Ph.D., MICHAEL H. ELLMAN, M.D.,
BRUCE BENNIN, M.D., DAVID E. FRETZIN, M.D./CHICAGO

Panniculitis mimicking Weber-Christian Disease, induced by self inoculation of pentazocine, was seen in a 50-year old patient. The factitial nature of the skin nodules was proven by the presence of multiple, small birefringent particles seen under partially polarized light microscopy of the biopsy specimens.

Factitial panniculitis induced by self injection of pentazocine*¹ and meperidine hydrochloride†² may closely simulate Weber-Christian disease.³ When panniculitis is induced by self injection of drugs,

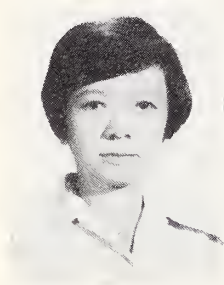
birefringent foreign material may be seen by polarized microscopy in biopsy specimens of involved skin.² We wish to report a case of factitial panniculitis induced by pentazocine administration, initially diagnosed

as Weber-Christian disease, in order to remind physicians of this unusual but perhaps not so rare entity.^{1,2}

Case Report

A 50-year old black woman was seen at the Arthritis Clinic of Michael Reese Medical Center with the chief complaint of chronic, painful skin nodules of the thighs and buttocks. Painful, discrete nodular skin lesions of the thighs associated with fever first appeared in 1972 and spontaneously resolved within one year. The lesions reappeared in 1974 as multiple, red, hot and painful nodules again involving her thighs and buttocks draining whitish foamy material. Weber-Christian disease was diagnosed at another hospital after clinical evaluation and surgical biopsy. The patient was purportedly instructed to inject pentazocine and promazine§ intramuscularly into her buttocks for relief of pain. Past history revealed no major illnesses except for severe migraine headaches that required hospitalization and use of parenteral analgesics.

On physical examination she had multiple indurated, erythematous solitary to coalescing skin and subcutaneous nodules ranging in size from 2 cm to more than 10 cm in diameter. They involved both prox-



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*Talwin

†Demerol

§Sparine

imal thigh areas, (Figure 1) buttocks and the right side of the anterior abdominal wall. Several nodules were also found on the posterior aspect of the right calf. A few nodules on either side of her thighs were draining purulent material. Older healed lesions appeared fibrotic and atrophic.

Hospital evaluation was entirely normal except for eosinophilia on three occasions ranging from 5 to 12%, urinalyses with trace proteinuria and an erythrocyte sedimentation rate (Westergren) of 58 mm/hr. A lipid profile by agarose gel electrophoresis showed Type II-A hyperlipoproteinemia; amylase, lipase and α -1-antitrypsin values were within normal limits. The antinuclear antibody test and complement levels were negative or normal. Chest and femur roentgenograms were normal.

Multiple surgical biopsies of new and healed subcutaneous nodules were obtained. Cultures and stains for acid-fast bacilli and fungi were negative. Histopathologic examination of a new lesion revealed acute and chronic inflammation of the subcutaneous tissue with

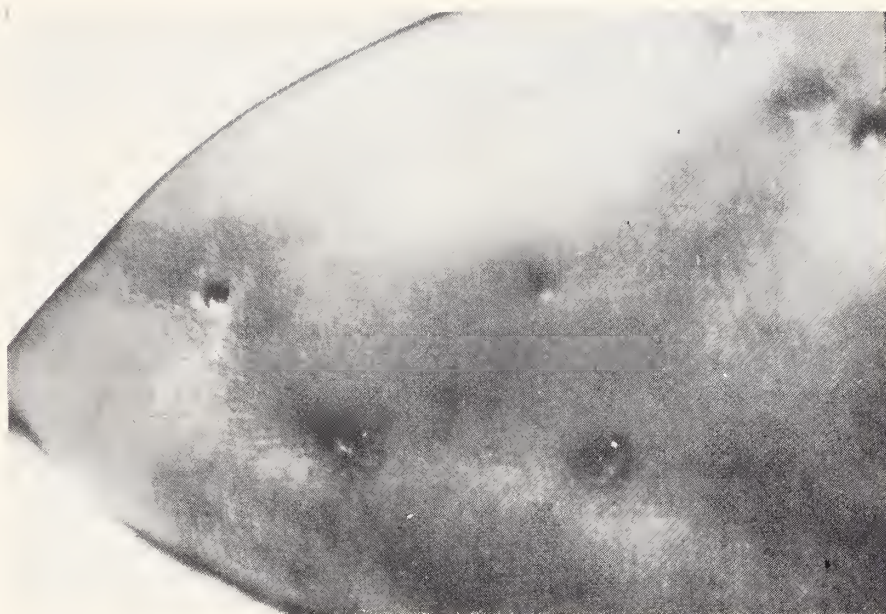


Figure 1
Photograph of both thighs showing multiple, indurated, erythematous skin nodules with a few ulcerated lesions.

infiltration by polymorphonuclear leukocytes, eosinophils, lymphocytes, histiocytes, giant cells and foamy histiocytes as well as focal necrosis. Older lesions showed less inflammation and considerable fi-

brosis. Polarized microscopy revealed multiple, birefringent small crystal-like particles in both old and new lesions (Figure 2) supporting the diagnosis of factitial panniculitis.

The patient was informed of the histologic finding of foreign material in the skin biopsies. This prompted admission of self administration of pentazocine for migraine headaches prior to the onset of skin nodules with the subsequent development of addiction to this drug. She was relieved to know that she had no primary panniculitis and agreed to participate in a drug withdrawal program.

Discussion

The general features of Weber-Christian disease are relapsing nodular non-suppurative panniculitis often associated with fever, leukocytosis and eosinophilia. It is a disease of unknown etiology with a female predominance. In the localized form involving only the panniculus adiposus, it is a rather benign disease and resolution usually occurs following months or years of active lesions. Cases associated with a variety of systemic manifestations have been described. In re-

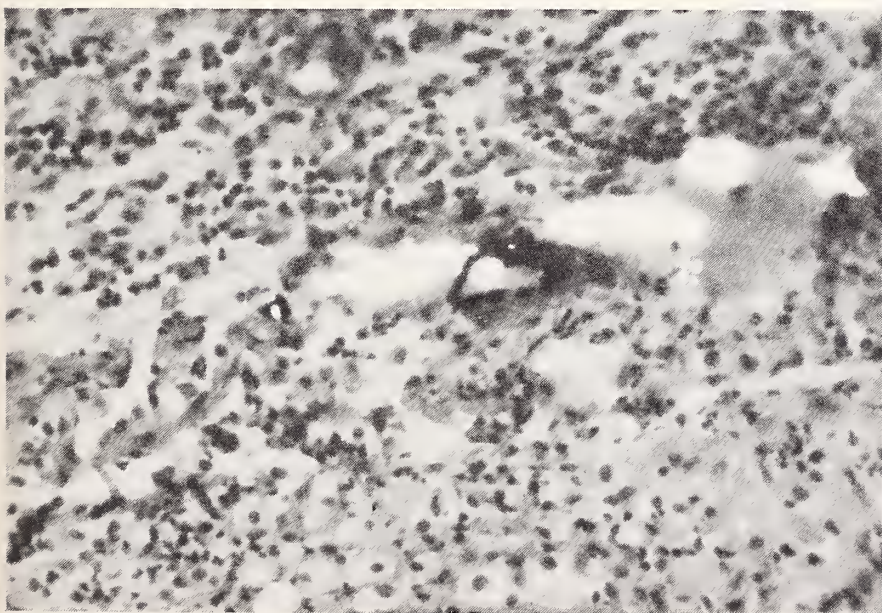


Figure 2
Photomicrograph of skin biopsy showing multiple birefringent particles surrounded by inflammatory cells when examined under partially polarized microscopy. Original magnification X 120.

viewing the literature, MacDonald and Feiweil proposed that Weber-Christian disease is not a distinct clinical entity and the term nodular panniculitis be used instead when the etiologic factor(s) is not known.³ There is a more malignant form of systemic Weber-Christian disease involving visceral organs including pleura, lungs, bowels, kidneys and mesenteric adipose tissues.⁴ More recently, the syndrome of subcutaneous fat necrosis, polyarthritis, polyserositis and pancreatic disease was described.⁵⁻⁷ The relationship of this clinical entity to systemic Weber-Christian disease remains obscure. When visceral involvement of fat necrosis is extensive, the disease may be fatal.

Our patient presented clinically with extensive involvement of non-suppurative subcutaneous panniculitis. Histopathologic examination of biopsy tissues by routine light

microscopy did not help in the differential diagnosis of Weber-Christian disease versus factitial panniculitis. In our patient, crystalline material was seen in all biopsy specimens under polarized light microscopy leading to the diagnosis of factitial panniculitis. Förström and Winkelmann have emphasized the usefulness of polarized light microscopy in the differential diagnosis of Weber-Christian disease in their two cases and we agree with them that this technique should be routinely used. In our patient, the cessation of surreptitious intramuscular injections of pentazocine and promazine prompted remission.

References

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3. MacDonald, A. and Feiweil, M.: "A Review of the Concept of Weber-Christian Panniculitis with a Report of Five Cases," *Brit. J. Derm.* 80:355-361, 1968.
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5. Gibson, T. J., Schumacher, H. R., Pascual, E., and Brighton, C.: "Arthropathy, Skin and Bone Lesions in Pancreatic Disease," *J. Rheum.* 2:7-13, 1975.
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7. Tannenbaum, H., Anderson, L. G., and Schar, P. H.: "Association of Polyarthritis, Subcutaneous Nodules, and Pancreatic Disease," *J. Rheum.* 2:14-20, 1975.



New ISMS Membership Service

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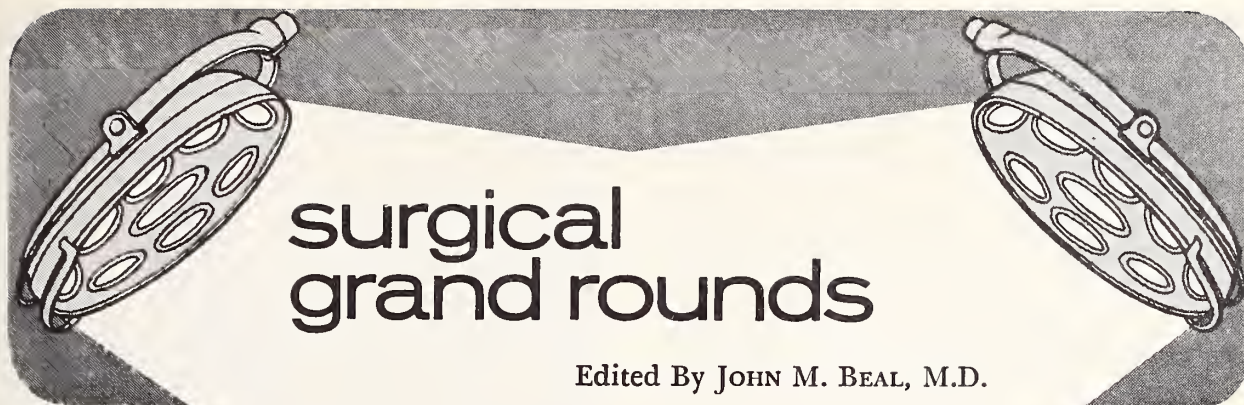
In January, when ISMS membership cards are distributed, a special number will be printed on the face. This AID number identifies your eligibility for a special discount program.

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Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 8, 1978.

Case Report

Branchial Cleft Cyst

Dr. David Katrana: A 22-year-old Caucasian girl complained of a painless mass in her neck. She stated that the mass was noted approximately 10 years ago. During this period, she had noticed some fluctuation in size, but recently it had markedly increased. It had not been inflamed or painful, nor had it drained. She did not have a history of a significant dental or intraoral inflammatory process. She was in good general health.

Her past medical history was insignificant, excepting a severe episode of streptococcal infection with a toxic course at age 10 years. She had been hospitalized and rheumatic fever was diagnosed. A residual heart murmur was noted but she has not manifested any clinical sequelae. Her history included a tonsillectomy and wisdom teeth extraction.

On physical examination, positive findings were confined to the mass in her neck, which was three cm in diameter. It was soft, mobile beneath the skin, but apparently fixed to deep structures. It was painless and there was no intraoral manifestation of disease. No evidence was found of oropharyngeal infection or inflammation. There was a grade two over six systolic ejection murmur at the sternal border. Her preoperative laboratory studies including blood

count, chest X-ray, and urinalysis were within normal limits.

She was given 600,000 units of aqueous penicillin and 600,000 units of procaine penicillin prior to operation and the neck was explored under endotracheal anesthesia. There was a small stalk associated with the mass, but it did not communicate with either pharynx or external auditory canal.

Dr. Ryoichi Oyasu: The specimen consisted of a cystic mass, 2.5 cm in diameter, bounded by fibroadipose tissue. The content of the cyst was cheesy brown material. Microscopically, the wall of the cyst varied in thickness, accompanied with varying amounts of lymphoid tissue, (Fig. 1) with or without germinal centers. The inner surface was lined by keratinizing stratified squamous epithelium. Outside the cyst wall, foreign body giant cell reaction was found in some areas, apparently as a reaction to the spilled content of the cyst. The typical branchial cleft cyst may be lined by either stratified squamous or stratified columnar epithelium or a combination of both types. In this particular case, however, the entire cyst was made up of squamous epithelium.

From the pathological point of view, differential diagnoses include an epidermoid cyst and a cystic metastasis of squamous cell carcinoma to lymph node. The former can be excluded be-

cause of lack of lymphoid tissue outside the cyst wall, and the latter may be ruled out because of lack of atypia in the epithelial component.

Dr. David Katrana: The patient had an uneventful postoperative recovery. She went home the day after operation and received penicillin for two days postoperatively. We felt that she required prophylactic antibiotics for several reasons: she had evidence of rheumatic heart disease and antibiotic therapy reduced the risk of damage to her heart from bacteremia of the surgery or of the endotracheal tube. If we needed to go into her mouth and trace the tract of this cyst, penicillin would afford additional protection to the wound.

Pertinent Background Information

The branchial arches begin to develop about the fourth fetal week, and tissue rests trapped during this time have been associated with residual cysts in the area. The embryology is important in predicting the location of cyst tracts. For instance, the first branchial arch is responsible for producing the maxillary and mandibular processes. Its associated internal pouch and external groove contribute to the development of the eustachian tube and external auditory canal. The second arch is responsible for a portion of the upper neck skin and its pouch produces the tonsillar fossa.

In the process of obliteration of the grooves and pouches in development of these structures, it is felt that cellular rests are left within the tissue. These can later manifest themselves either as a cyst, sinus, or fistula, depending on the anatomy that is present. A sinus is defined as an opening onto either skin or mucosa surface and a fistula as a penetrating defect.

The branchial cleft cysts are associated with second branchial groove pouch and arch in 95% of occurrences. The remnant of the second branchial pouch is the tonsillar fossa and a tract that persists in the course of the migration of the arch downward on to the neck follows the arch in its development. For this reason, the lesion in a second branchial cleft anomaly most commonly manifests in the area of the carotid triangle, and a tract, if present, extends toward the tonsillar fossa. The tract will frequently go between internal and external carotid adjacent to glossopharyngeal and hypoglossal nerves, deep to the posterior belly of the digastric. In this event, it will exit in the posterior aspect of the tonsillar fossa, and sometimes through the tonsil itself, if it is present.

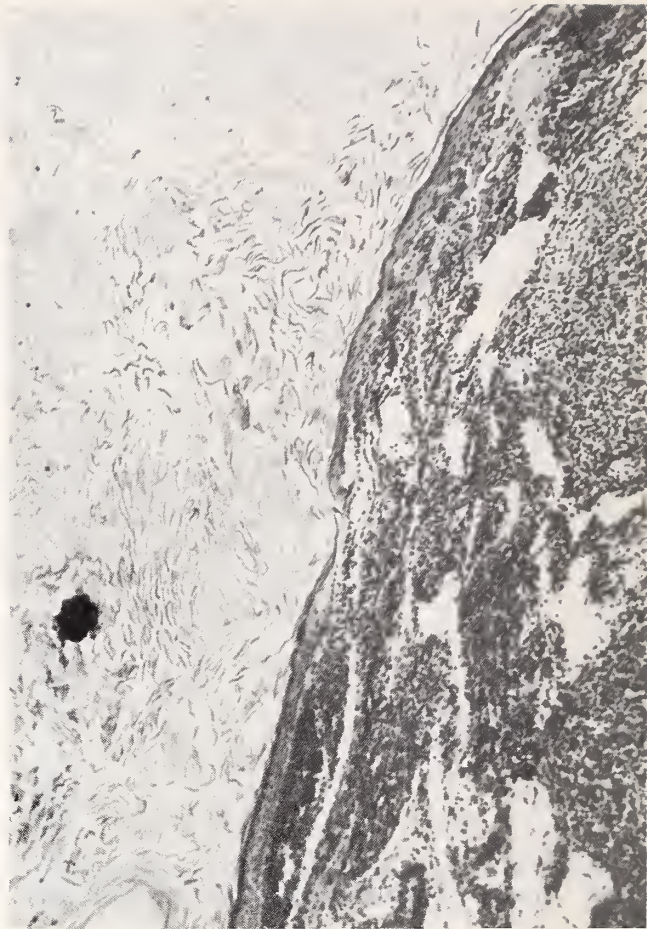


Figure 1
Wall of cyst contains lymphoid tissue and is lined with stratified squamous epithelium.

Anomalies of the first arch are usually located along the horizontal part of the mandible and tract past the carotid in close junction with the trunk of the cranial nerve, and up into the area of the external auditory canal. In fact, a draining external fistula and a draining ear canal are pathognomonic of this fistula, assuming primary ear disease is ruled out.

Thyroglossal Duct Cysts

A discussion of congenital neck cysts should also include those associated with the thyroglossal duct. The foramen cecum at the base of the tongue is the origin of the thyroglossal duct which migrates down in the neck through the hyoid bone, and ends in the midneck at the thyroid gland. Development begins about the same time embryologically as the first and second branchial arches, and the anomaly most commonly manifests as a midline neck mass. Motion with swallowing is characteristic. As the hyoid

bone moves with the pharynx on swallowing, the tract through it puts tension on the cyst. A thyroid scan is frequently indicated in these patients to prove the presence of functioning thyroid tissue and that indeed the mass is not the only thyroid tissue present.

The recurrence rate of thyroglossal duct cysts has been reported as high as 20% and is usually essentially considered an incomplete resection. It is mandatory to excise the central portion of the hyoid bone and follow the tract even to the base of the tongue if necessary.

A brief differential diagnosis of neck lesions would seem indicated. An isolated neck mass in a child is most commonly inflammatory in origin and the second most common mass is associated with lymphomas. In an adult, a neck mass is considered carcinoma until proven otherwise as 85% have been found to be metastatic and the remaining 15% primary. Of the metastatic, again, 85% are associated with the head and neck and the other 15% are from lesions located below the clavicle. Surgical excision of congenital cysts in the neck must not be taken lightly. They require endotracheal anesthesia and preparations to follow the tract to its inter-

nal origin if necessary. Multiple vital structures are associated with the dissection and require total surgical and anesthetic control as described.

Dr. Peter McKinney: The essential points are that because the first and second arches grow in a caudal direction they can cover over the folds and the grooves. If these are not completely obliterated, a cyst of this nature can develop. If it is lateral, you have to be prepared to dissect to the tonsillar bed or to the ear. If it is midline, you must be prepared to go to the base of the tongue. The treatment is entirely surgical. Some of the literature discusses incisions, aspirations or sclerosing solutions, but these are useless. The horizontal incisions are to be preferred in the neck, of course, and subcuticular sutures avoid suture marks. With a fistula, there may be drainage on the outer aspect of the neck and in our experience this has indicated a tract to the pharynx. With an isolated cyst, this is unlikely but must be considered. The recurrence rate should be quite low; malignancy is possible but not common. In very rare instances, these masses represent functioning thyroid tissue. ◀

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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

DECEMBER

Colposcopy

COLPOSCOPY

For: MD's. Conference, Dec. 8-9, Chicago. Sponsor: Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago 60611. Fee: \$150. CME Credit: AMA Category 1, 12 hours. Contact: James Dyson, Ph.D. Phone: 312-649-8533.

Family Medicine

UPDATE—PRIMARY CARE MEDICINE

For: GP's, FP's, Internists. Lectures, Dec. 12 & 15, 8:00 a.m., Chicago. Sponsor: Grant Hospital, 550 W. Webster, Chicago 60614. Fee: none. Reg. limit: none. CME Credit: AMA Category 1, 2 hours. Contact: P. Colon. Phone: 312-883-2112.

Family Therapy

TECHNIQUES FOR WORKING WITH SEVERELY DISTURBED FAMILIES

For: MD's. Workshop, Dec. 1, 9:30-4:30 p.m., Chicago. Speaker: Froma Walsh, Ph.D. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. CME Credit: AMA Category 1, 6 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

Internal Medicine

JAUNDICE

For: MD's, office staff. Symposium, Dec. 7, 1:00-5:00 p.m., DuQuoin. Sponsor: SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL. Fee: \$25 pre. Reg. limit: none. CME Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

MEDICAL ASPECTS OF ALCOHOLISM

For: MD's, students, general public. Seminar, Dec. 1, 1:00-4:00 p.m., Palmer House, Chicago. Sponsor: Illinois State Medical Society. Credit: AMA Category 2, 3 hours. Fee: none. Reg. limit: none. Contact: Debbie Frei-Lahr, 5553 So. Ingleside, Chicago, IL 60637. Phone: 312-955-6267.

Obstetrics/Gynecology

OBSTETRICS & OFFICE GYNECOLOGY

For: MD's, office staff. Symposium, Dec. 7, 5:00-9:00 p.m., Lawrenceville. Sponsor: SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. Fee: \$25 pre. Reg. limit: none. CME Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Psychiatry

INTRODUCTION TO THE ART OF SELF-CARE & CONFLICT MANAGEMENT

For: Psychiatrists, MD's. Lecture, Dec. 20, 1:00-4:00 p.m., Forest Park. Speaker: Yetta Bernhard, MS. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. Fee: \$15. CME Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312-771-7000.

Psychiatry

OFFICE PSYCHIATRY

For: MD's, office staff. Symposium, Dec. 14, 7:00-10:00 p.m., Effingham. Sponsor: SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. Fee: \$25 pre. Reg. limit: none. CME Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Urology

SPECIALTY REVIEW IN UROLOGIC PATHOLOGY

For: Urologists. 4-day lecture, Dec. 4, Chicago. Speakers: Thomas John, MD.; Irving Bush, MD. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL 60612. Fee: \$200. Reg. limit: 100. Credit: AMA Category 1, 32 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

JANUARY

Family Medicine

ETHICAL ISSUES IN CRITICAL CARE

For: GP's. Lecture, Jan. 10, 2:00-5:00 p.m., Chicago. Sponsor: The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago 60637. Fee: \$20. Reg. limit: none. CME Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Elaine Ehrman. Phone: 312-947-5777.

Family Medicine

UPDATE—PRIMARY CARE MEDICINE

For: GP's, FP's, Internists. Lectures, Jan. 5 & 26, 8:00 a.m., Chicago. Sponsor: Grant Hospital, 550 W. Webster, Chicago 60614. Fee: none. Reg. limit: none. CME Credit: AMA Category 1, 2 hours. Contact: P. Colon. Phone: 312-883-2112.

Family Medicine

9TH ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS

For: FP's. 3-day course, Jan. 17-19, Pfister Hotel, Milwaukee, Wisc. Sponsor: Department of Family Practice, The Medical College of Wisconsin, 610 North 19th St., Milwaukee, Wisc. 53233. Cosponsor: SE Chapter, Wisconsin Academy of Family Physicians. Reg. deadline: 1/5. Fee: \$160. Reg. limit: 225. Credit: AAFP Prescribed, 21 hours; AMA Category 1, 21 hours. Contact: Susanna Rechlit. Phone: 414-933-0700.

Internal Medicine

RHEUMATIC DISEASES: CURRENT CONCEPTS OF PATHOGENESIS, DIAGNOSIS AND MANAGEMENT

For: Rheumatologists, Internists, FP's. Lecture, Jan. 18, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, Ann Arbor, Michigan 48109. Fee: \$130. Reg. limit: 400. Credit: AAFP Prescribed, 18 hours; AMA Category 1, 18 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Medical/Legal

24TH MEDICAL/LEGAL SEMINAR FOR LAKE COUNTY

For: MD's. Seminar, Jan. 24, 8:00 a.m., Waukegan. Sponsor: St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. Fee: \$25. Credit: AMA Category 1, 5 hours. Contact: R. M. Adelman, MD. Phone: 312-688-6461.

Medicine

14th ANNUAL MEETING

For: FP's. Symposium/workshop, Jan. 14-19, Las Vegas, Nevada. Speaker: Michael De Bakey, MD. Fee: \$250. Reg. limit: none. CME Credit: AMA Category 1, 40 hours. Sponsor: American Society of Contemporary Medicine and Surgery, 6 No. Michigan Ave., Chicago 60602. Contact: John Bellows, MD. Phone: 312-236-4673.

Family Therapy

PERSONAL/PROFESSIONAL GROWTH WORKSHOP THERAPISTS: WITH OR WITHOUT PARTNERS

For: MD's, therapists. Seminar, Jan. 25, 26, Oak Park. Speaker: Charles Kramer, MD. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$16. CME Credit: AMA Category 1, 17 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

Family Therapy

LAW IN THE EVERYDAY PRACTICE OF PSYCHOTHERAPY

For: MD's. Workshop, Jan. 26 & 27, 9:30-4:30 p.m., Chicago. Speaker: Sandra Nye, JD, MSW. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$40. CME Credit: AMA Category 1, 12 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

Ophthalmology

14th ANNUAL SCIENTIFIC ASSEMBLY

For: Ophthalmologists. Seminars/lectures/workshop, Jan. 14-19, Las Vegas, Nevada. Sponsor: American Society of Contemporary Ophthalmology, 6 No. Michigan Ave., Chicago 60602. Fee: \$250. Reg. limit: none. CME Credit: AMA Category 1, 40 hours. Contact: John Bellows, MD. Phone: 312-236-4673.

Ophthalmology

THE ROLE OF THE PRIMARY PHYSICIAN IN EYE CARE

For: FP's, Internists, Pediatricians. Workshop, 3 sessions in 1979, Chicago. Sponsor: Dept. of Ophthalmology, University of Illinois, 1855 W. Taylor, Chicago 60612. Fee: \$200/session. Reg. limit: 40. Credit: AMA Category 1. Contact: Carmen Carrara. Phone: 312-996-8023.

Psychiatry/Psychology

NARCISSISTIC FACTORS IN PSYCHOTHERAPY

For: MD's, Psychiatrists. Lecture, Jan. 17, 1:40-4:00 p.m., Forest Park. Speaker: Arnold Goldberg, MD. Sponsor: Riveredge Hospital Foundation, 8311 Roosevelt Rd., Forest Park 60130. Fee: \$15. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312-771-7000.

FEBRUARY

Anesthesiology

REGIONAL ANESTHESIA

For: Anesthesiologists. 5-day lecture, Feb. 26, Chicago. Speaker: Vincent Collins, MD. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL 60612. Fee: \$325. Reg. limit: none. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Ear, Nose and Throat

COMMON EAR, NOSE AND THROAT PROBLEMS

For: GP's. Lecture, Feb. 14, 1:30-4:45 p.m., Chicago. Sponsor: The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637. Fee: \$20. Reg. limit: none. Credit: AAFP Elective, 3 hours; AMA Category 1, 3 hours. Contact: Mrs. Elaine Ehrman. Phone: 312-947-5777.

Emergency Care

EMERGENCY MEDICINE

For: FP's, Emergency MD's. Lecture/workshop, Feb. 19-23, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Towsley Center for CME, Ann Arbor, Michigan 48109. **Cosponsor:** American College of Emergency Physicians, Michigan Affiliate. **Fee:** \$275. **Reg. limit:** 500. **Credit:** AAFP Prescribed, 35 hours; AMA Category 1, 35 hours. **Contact:** Floyd Pennington. **Phone:** 313-764-2287.

Family Medicine

UPDATE—PRIMARY CARE MEDICINE

For: GP's, FP's, Internists. Lectures, Feb. 2, 16, 23, 3:00 a.m., Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago, IL 60614. **Fee:** none. **Reg. limit:** none. **Credit:** AMA Category 1, 3 hours. **Contact:** Ms. J. Colon. **Phone:** 312-883-2112.

Family Medicine

CLINICAL MEDICINE UPDATE

For: GP's, FP's. 5-day lecture, Feb. 19, Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL 60612. **Fee:** \$225. **Reg. limit:** 200. **Credit:** AMA Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Family Therapy

THE THERAPIST'S OWN FAMILY

For: Therapists. Lecture series, Feb.-June, 9:00-1:00 p.m., Oak Park. **Speaker:** Jeannette Kramer. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. **Cosponsor:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Fee:** \$150. **Reg. limit:** none. **Credit:** AMA Category 1, 20 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

Family Therapy

FAMILY SYSTEMS ASSESSMENT—INTRODUCTORY COURSE

For: Therapists. Course, Feb. 5-9, Chicago. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. **Cosponsor:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Fee:** \$155. **Credit:** AMA Category 1, 27.5 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

Family Therapy

INTEGRATION OF CULTURAL HISTORY INTO ASSESSMENT AND INTERVENTION

For: Therapists. 3-day conference, Feb. 22-24, Chicago. **Speakers:** George Vassiliou, MD., Vasso Vassiliou, PhD. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago, IL 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Fee:** \$120. **Credit:** AMA Category 1, 18 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

Family Therapy

STRATEGIES AND TECHNIQUES—INTERMEDIATE COURSE

For: Therapists. Course, Feb. 12-16, Chicago. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. **Cosponsor:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Credit:** AMA Category 1, 27.5 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

Forensic Medicine

REVIEW OF CURRENT FORENSIC PATHOLOGY CASES

For: MD's, DDS's, LIB's. Lecture/workshop, Thursdays, 2:00 p.m., Chicago. **Sponsor:** Office of the Medical Examiner, Cook County, IL, 1828 West Polk St., Chicago, IL 60612. **Fee:** none. **Reg. limit:** 50. **Contact:** Robert Stein, MD. **Phone:** 312-443-5017.

Internal Medicine

USE OF THE LABORATORY IN CLINICAL PRACTICE

For: Internists, FP's, GP's. Symposium, Feb. 22-23, St. Louis, Missouri. **Sponsor:** Office of CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. **Fee:** \$120. **Reg. limit:** 150. **Credit:** AAFP Elective, 12 hours; AMA Category 1, 12 hours. **Contact:** Loretta Giacometti. **Phone:** 314-454-3873.

Internal Medicine

START TODAY

For: Internists, FP's, GP's. Symposium, Feb. 15-16, St. Louis, Missouri. **Sponsor:** Office of CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. **Fee:** \$120. **Reg. limit:** 150. **Credit:** AAFP Elective, 12 hours; AMA Category 1, 12 hours. **Contact:** Loretta Giacometti. **Phone:** 314-454-3873.

Neurology

NEUROLOGY, PART I, BASIC

For: Neurologists, Psychiatrists. 5½-day Lecture, Feb. 26, Chicago. **Speaker:** Neil Allen, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. **Fee:** \$250. **Reg. limit:** 150. **Credit:** AMA Category 1, 44 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Psychiatry

TOPICS IN PSYCHOSOMATIC AND BEHAVIORAL MEDICINE

For: Psychiatrists, primary care physicians. Lecture, Feb. 27-28, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Towsley Center for CME, Ann Arbor, Michigan 48109. **Fee:** \$120. **Reg. limit:** 350. **Credit:** AAFP Prescribed, 14 hours; AMA Category 1, 14 hours. **Contact:** Floyd Pennington. **Phone:** 313-764-2287.

Psychiatry

SYSTEMS AND STRATEGIES IN FAMILY THERAPY

For: Psychiatrists. Lecture, Feb. 21, 1:00-4:00 p.m., Forest Park. **Speaker:** Peggy Papp, ACSW. **Sponsor:** Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. **Fee:** \$15. **Credit:** AMA Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312-771-7000.

Surgery

SPECIALTY REVIEW COURSE IN THORACIC SURGERY

For: General and Cardiothoracic Surgeons. 6-day lecture, Feb. 13, Chicago. **Speaker:** Sidney Levitsky, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. **Fee:** \$250. **Reg. limit:** 200. **Credit:** AMA Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Surgery

SPECIAL REVIEW COURSE IN NEUROLOGICAL SURGERY

For: Neurosurgeons, Neurologists. 10-day lecture, Feb. 2, Chicago. **Speaker:** Leonard Kranzler, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. **Fee:** \$425. **Reg. limit:** 250. **Credit:** AMA Category 1, 104 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Cancer—Educational Materials

A variety of reprints, motion pictures (8mm and 16mm), tapes, slides, and exhibits are available from the American Cancer Society's Illinois office. That agency also maintains a speakers bureau. Topics covered include both physiological and psychological aspects; material is available to meet the needs of physicians, nurses, and patients.

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Introduction to CME Techniques

Two-day intensive workshop, Dec. 1-2. For: Hospital DME's, Program Chairmen, Medical Faculty, CME Planners. Leaders: Donald F. Pochly, M.D., and Leonard S. Stein, Ph.D. **Sponsor:** ICCME. Oak Brook Hyatt House, Oak Brook, IL. **Credit:** AMA and IL license Category 1, 14 hours. **Contact:** Diane Wolniewicz, ICCME, 55 E. Monroe, Chicago 60603. **Phone:** (312) 236-6110.

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Berwyn—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4

Beverly—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4

Centralia—Feb. 21; Mar. 7, 21

Champaign—Mar. 1, 15, 29

Chicago Nearwest—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4

Chicago North—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4

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Harvey—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4

Hinsdale—Feb. 21; Mar. 7, 21

Melrose Park—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4

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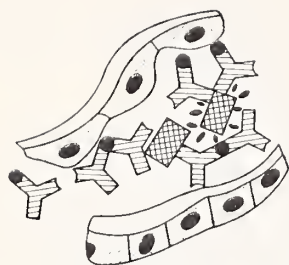
Peoria—Feb. 22; Mar. 8, 22

Rockford—Mar. 1, 15, 29

Rock Island—Feb. 22; Mar. 8, 22

Springfield—Mar. 1, 29

For complete information, contact: Illinois Academy of Family Physicians, 1200 Harger Road, Suite 405, Oak Brook, Illinois 60521. **Phone:** 312-325-8502.



Seminars In Immunopathology and Oncology

RICHARD J. ABLIN, PH.D., CONTRIBUTING EDITOR

Immune Complexes and Human Disease

BY BRIAN S. ANDREWS, BSc (Med) AND RONALD PENNY, M.D./SYDNEY, AUSTRALIA

This is the conclusion of a three part special overview series for the "Seminars in Immunopathology and Oncology." In part one, Doctors Pennsy and Andrews delineated the historical background to immune complex research. Part two, exploring detection of immune complexes, was published in the September IMJ. This concluding portion considers general management criteria.

General Management of an Immune Complex Disorder

An IC disease should be suspected either by the distribution or nature of the basic immunopathologic process. Specific questions should be raised regarding a possible underlying disease (SLE, ulcerative colitis); possible Ag(s) involved (drugs, tumor infectious agents) and initiating factors (drugs, UV-irradiation).

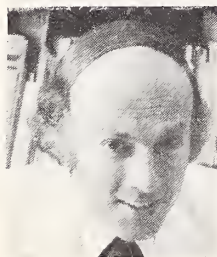
Once suspected, an IC disease should be confirmed by demonstration of the complex in serum

and the finding of a consistent histopathologic picture coupled with identification of Ig and C components in the tissues. Examination of serum for circulating ICs should include a combination of techniques to identify functional characteristics of the complex(es). If ICs are demonstrated in one site, a careful evaluation of other high risk sites (kidney, skin, joint, eye) should be made.

As indicated (Table 6) there are both theoretical and practical approaches to the management of a patient with circulating ICs; the approach depends on disease severity and if indications for specific therapy exist. First, the composition of the IC may be modified by manipulating the Ag. This may be achieved by avoiding exposure to the Ag, eliminating an infectious agent or diminishing the inflammatory response whereby autoantigens may be liberated in the serum. The latter applies specifically to active SLE, where the use of corticosteroids may reduce the release of cellular DNA at the inflammatory site. In theory, specific enzymic destruction of Ag by penicillinase or DNase may play a future role. If the Ag can be identified, administration of excess nonpathogenic Ag may reduce the half-life of the circulating or tissue IC. In experimental chronic serum sickness, administration of excess Ag aided in clearance of Ag from



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RONALD PENNY, M.D., F.R.C.P., is an associate professor of medicine and director of the department of Immunology at the University of New South Wales at St. Vincent's Hospital in Sydney, Australia. Doctor Penny initiated his research in immunology and immunopathology at the Institute of Cancer Research at New York's Columbia University.

Abbreviations

Ab	Antibody
Ag	Antigen
C	Complement
IC(s)	Immune Complex (es)
Ig	Immunoglobulin
GN	Glomerulonephritis
MPS	Mononuclear phagocytic system
PEG	Polyethylene glycol
PMN	Polymorphonuclear leukocyte
RA	Rheumatoid arthritis
RF	Rheumatoid factor
RIA	Radioimmune assay
SLE	Systemic lupus erythematosus

the glomerulus.⁴ Further, excess Ag may lead to reduced Ab synthesis by producing high dose tolerance, possibly activating suppressor T-cells. Transfer factor has been employed in anergic patients with persistent hepatitis B-induced hepatitis and IC disease.¹⁰⁵ It was proposed that clearance of intracellular virus would reduce the overall Ag load and subsequent pathogenetic IC formation.

Secondly, the Ab may be modified by specific drugs. Corticosteroids¹⁸² and immunosuppressive agents¹⁸³ will reduce Ig synthesis over a period of time. Antibody may possibly be destroyed by

a drug such as penicillamine which is effective in severe RA and is associated with a reduction in serum IgG and IgM and RF activity.¹⁸⁴ Conversely, an increase in Ab level may result from infusion of specific Ab or by immunization. It could be anticipated that Ab excess complexes would be formed with rapid clearance from the circulation. This presupposes that the more phlogistic complexes will be cleared by a mononuclear phagocytic system which is functioning normally, which may not be so.

Thirdly, ICs may be removed directly from serum by plasmapheresis.^{58,96,185,186} This technique has been applied successfully to the management of patients with active SLE, mixed cryoglobulinemia and "blocking factors" in serum associated with malignant disease. In addition, specific autoantibodies can be removed in Goodpasture's Syndrome and in thrombocytopenic purpura, allowing easier control of the disease process. In the future, plasmapheresis incorporating a selective removal system for complexes may be possible.

Fourthly, mononuclear phagocytic function may be increased by drugs such as Levamisole which may enhance clearance of larger C-fixing ICs.¹⁸⁷

In practice, however, the management of IC disorders involves modification of the biological sequelae which follow IC formation (Table 6).

Table 64,13,14,35,58,96,105,182-192

Approaches to the Management of Immune Complex Disorders

- A. *Modify Antigen-Antibody Composition of the Complex*
 1. *Antigen*—Avoid exposure; eliminate microorganism; decrease release of auto-antigens e.g. DNA; destroy antigen^d, e.g. penicillinase, DNase; transfer factor; administer excess antigen.^d
 2. *Antibody*—Decrease antibody production; increase antibody level;^d destroy the antibody e.g. penicillamine.
- B. *Remove the Immune Complex*
 1. Plasmapheresis or selective removal^d incorporating plasmapheresis.
 2. Increase mononuclear phagocytic function e.g. Levamisole.
- C. *Limit Biological Sequelae Produced by Immune Complexes*
 1. Limit interaction with cellular receptors, e.g. block Fc receptors on platelets, eosinophils, PMNs and mononuclear phagocytes by infusing Fc fragments.^d
 2. Block effects of cell-bound complexes e.g. limit platelet aggregation and vasoactive amine release by salicylates and dipyridamole.
 3. Reduce effects of released mediators e.g. antihistamines, antiserotonins.
 4. Reduce microvascular coagulation and increase clearance of fibrin by heparin and fibrinolytic therapy respectively.
 5. Inhibit prostaglandin synthesis by salicylates or Indomethacin.
 6. Reduce overall inflammatory response e.g. corticosteroids.

^dTheoretical approaches.

The therapy depends on the severity of the disease process and the organ(s) involved, in particular, brain, retina, heart, and kidneys. With severe inflammatory disease corticosteroids are generally indicated to reduce the overall inflammatory response; their exact mechanism of action is not clearly understood. In addition, immunosuppressive agents (cyclophosphamide, chlorambucil, azathioprine) may be helpful in reducing Ab synthesis and the cell-mediated immune response, but particularly in their steroid-sparing capacity or for control of the disease process if corticosteroids alone are ineffective.^{182,183}

When the inflammatory process is not severe and does not significantly compromise vital organ function, other alternatives are available. The effect of cell-bound ICs may be modified by reducing platelet aggregation with the subsequent release of nucleotides and vasoactive amines; this is achieved by salicylates (300-600 mg/day) with or without dipyridamole (25 mg qid).¹⁸⁸ To reduce the effect of histamine and serotonin which may be released from basophils, mast cells and platelets, cyproheptadine may be effective (4 mg tid); this agent blocks both histamine and serotonin binding.^{20,29} With any inflammatory process there is usually some element

of microvascular coagulation and fibrin (ogen) deposition. Heparin will reduce the former¹⁸⁹ while fibrinolytic therapy will aid clearance of the latter. Fibrinolysis may be achieved by a combination of phenformin (25 mg qid) and an anabolic steroid, ethyl estranol (2 mg qid) or possibly by streptokinase if impaired fibrinolysis and fibrin deposition are marked.¹⁹⁰ Prostaglandins may exacerbate the inflammatory process; their formation can be reduced by drugs which inhibit prostaglandin synthetase (salicylates or indomethacin).¹⁹¹

In many situations, however, the nature of the Ag involved in IC formation is unknown with the treatment remaining empiric. Every attempt should be made to identify possible initiating Ag's or events which trigger IC formation, in order to avoid them in the future. ◀

This concludes our three part series on immune complexes and human disease. A complete list of references is available upon request to: Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago 60603.

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Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

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ATKINSON: Due to recent death of town's physician, a modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles from Peoria. All recreational facilities nearby. **CONTACT:** John W. Ellis, Mayor, Atkinson 61235. (309) 936-7566. (12)

AURORA: Opening in General Internal Medicine with 40 man group. Complete office facilities. Good starting salary. **Contact:** L. E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506. (312-859-6700) (1)

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virtues of small town living with the cultural and shopping assets of a large metropolitan area. Attractive salary, 40 hour work week and generous fringe benefits. IL license required. A.A./E.O.E. For further information send vitae to Don Knapp, M.D., Medical Director, SIU-C Health Service, Carbondale, IL 62901. (3)

CHICAGO: Major Chicago based retailer seeking corporate physician. Up-to-date, modern facilities, regular hours and comprehensive employee benefits make this a very desirable position. Please send resume with salary requirements. **Contact:** Professional Employment Director, Sears, Roebuck & Co., D/707-2, Chicago 60684 (1)

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LA GRANGE: Western suburb of Chicago, medium sized hospital. Opening for Director of medical affairs, new position, full time. Work with medical staff on CME, medical staff affairs, Family Practice Residency Program and University affiliation. Contact, Administrator, 312-352-1200. (2)

LISLE: Physician needed to assist me in handling my very extensive private family practice. Salary open, good opportunity for this relationship to merge into a partnership association. CONTACT: M. Sinkovits, 4513 Lincoln Ave., Lisle 60532. (312) 968-2735. (12)

MACOMB: GP-FP 12 month contract practice—University Health Service. Outpatient clinic—no OB, Surgery. Fringes include hospitalization, paid vacation, retirement, etc. Approximately 13,000 students, city 23,000. Competitive negotiable income. Equal opportunity affirmative action employer. Contact: C. E. Hughes, M.D., Director BEU Health Center, WIU, Macomb 61455. (1)

OSWEGO: Family physician or internist to join group of four in a small town primary care clinic. Two full-service hospitals nearby. One hour west of Chicago. Dr. A. Haan, Oswego, 60543. (312) 554-8431. (11)

PAXTON: Paxton Community Hospital is enlarging its medical staff due to expansion of the facility and has openings for Family Practitioners to locate in the community. A 30 bed, general short term acute hospital offers full services to the community except for OB. The hospital, in East Central Illinois, is approximately two hours from Chicago, St. Louis, and Indianapolis, and 30 minutes from University of Illinois. The hospital is fully accredited by the JCAH. Contact Mr. David Polge, Administrator, Paxton Community Hospital, 651 East Pells, Paxton 60957. Phone 217-379-2387. (12)

PEORIA: Economical sound central Illinois community of 250,000 situated in picturesque river valley has need for family physicians and general internists to practice in a 300 bed community hospital affiliated with the University of Illinois, College of Medicine. Office space and financial assistance available. "A GOOD PLACE TO PRACTICE GOOD MEDICINE." Contact: John A. Smith, Administrator, Proctor Community Hospital, 5409 N. Knoxville, Peoria 61614. (309-691-4702) (3)

WEST FRANKFORT: Population 10,000, county 42,000. Coal mining growth area (1,200 new jobs). Offices available near hospital. On I57/24 in Southern Illinois. Major university near. Good highways, and recreation. Need OB-GYN, IM-CV, IM-GP and FP. Financial assistance. Contact: Wm. D. Palmer, Administrator, UMWA Union Hospital, 507 W. St. Louis St., West Frankfort 62896. (618-932-2155) (1)

Weekend Workshop

Introduction to CME Technique

An intensive weekend workshop *FOR* Hospital DMEs and Program Chairmen,
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December 1-2, 1978

Friday 1:30 P.M. to Saturday 5:15 P.M.

Oak Brook Hyatt House, Dorset Room, Oak Brook, IL

This workshop takes account of the findings of both research and experience that physician continuing education is most satisfying if it occurs both individually and in groups at organized CME programs planned by the learners in the hospital setting. The workshop's overall goal is to offer an introduction to the basic elements of educational planning as they apply to CME.

For further details on program, schedule, and cost; write or call:

Illinois Council on Continuing Medical Education
55 East Monroe, Suite 3510, Chicago, Illinois 60603

Telephone: (312) 236-6110

IMPAC

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

Dear Doctor:

The election that this page has mentioned so frequently in the past months is over. All of the votes are cast and the outcome secure. I hope that some of you took IMPAC's advice and got involved in the campaign of the candidate of your choice and I'm sure that win or lose, that involvement along with the vote you cast on November 7th provided you with a meaningful and memorable experience---because you cared.

Perhaps those of you who didn't get involved or didn't vote can't understand the meaning of that experience; you care, but not as much as one who sacrificed his time, talents, sweat and heart. You probably are wondering what the big hub-bub is all about---after all, "it was *only* an election".

"*Only*" an election" - *only* the process by which we determine our own fate

only the way in which we pick our leaders

only the foundations upon which our republic was built

only the way in which the people impact their government.

Only...

It was once said that "Here sir, the people rule". But *only* with their efforts towards electing responsible legislators and *only* with their votes.

The blessing of democracy is that you always have another chance. There are less than two years until the 1980 primary, so you can start now to find out what it is all about. No one will thank you, but you'll discover what many have discovered before you---the excitement of invoking your rights as a citizen. Think about it, it's *only* a year and a half away.



Herbert Sohn, M.D.
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

Doctor's News

SPEAK UP FOR CHILDREN—The American Academy of Pediatrics has announced a national program in public education on child health issues. Initiated as a response to the declaration from the United Nations designating 1979 the International Year of the Child, the AAP will launch a four-pronged attack on public consciousness. Accident prevention, health education, immunization and nutrition will receive great emphasis in AAP efforts this year, according to Saul J. Robinson, M.D., AAP president.

In a related note, the September 8 issue of the *Journal of the American Medical Association* included an article reporting results of a physician poll on child abuse. The authors stated that while more than half of those responding reported seeing at least one identifiable sexually abused child annually, two-thirds of those polled said that they sometimes did not report these cases to authorities, because they felt that the cases could be better handled privately, and feared harm to the family. The other third noted a dissatisfaction with the manner in which state social service agencies handled such cases.

ALCOHOLISM UPDATE—A recent report from Alcoholics Anonymous cites an apparent demographic shift. A news release from Warsaw, Poland, reports that "the largest survey ever made of recovered alcoholics shows a nearly 50% increase since 1974 in the percentage of people under 30 years of age in Alcoholics Anonymous." The report also states that 32% of current AA members internationally are female. The data were released at the 32nd International Congress on Alcoholism and Drug Dependency, and refer to a survey of over 17,000 AA members worldwide.

In a related note, ISMS members are reminded that the ISMS Scientific Speakers Bureau now includes a roster of experts in alcoholism education. Their presentations are a part of a special program funded in part by a grant from the Illinois Department of Mental Health and Developmental Disabilities, Division of Alcoholism. Illinois' hospitals, county medical societies and medical schools are encouraged to sponsor alcoholism programs for their staff. For further information, please contact the ISMS offices, 55 E. Monroe, Suite 3510, Chicago, 60603.

DEPT. OF R & E ANNOUNCES NEW OFFICES—The Illinois Department of Registration and Education has announced that they will be moving their Springfield offices sometime late in 1978. The new address for correspondence to the Springfield office will be: 320 W. Washington Street, Springfield, 62786. The new telephone number in Springfield will be 217-785-0800. The Department's Chicago offices are not affected by this move. The Department has not yet announced the effective date of that move, other than to note that it will occur before year's end.

ICCME WORKSHOP ANNOUNCED—The Illinois Council on Continuing Medical Education will hold its annual workshop, "Introduction to CME Technique," at the Oak Brook Hyatt House on December 1 and 2, 1978. The workshop is designed for directors of medical education, program chairman, medical faculty and other CME planners. For further information, please contact ICCME, (312) 236-6110.

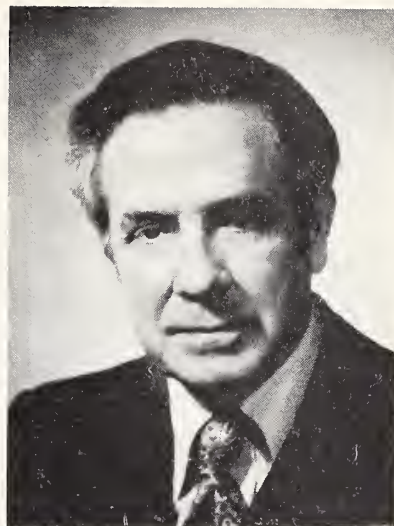
PHYSICIANS IN THE NEWS—The Illinois Chapter of the American Academy of Family Physicians elected new officers at their 30th annual meeting in Chicago. The new officers include: **Eugene Vickery, M.D.**, Lena, president-elect, **Leonora Nash, M.D.**, Moline, director, and **Eugene Welter, M.D.**, Aurora, vice president. **Delburt H. Nelson, M.D.**, Oak Lawn, was installed as IAFP president at that meeting. . . . The Illinois Chapter, American Academy of Pediatricians, recently elected **James P. Paulissen, M.D.**, Wheaton, and **James H. Cravens, M.D.**, Quincy, to join their Executive Committee for three year terms.

Three Illinois physicians received special honors in their fields this month. **James G. Dobbie**, a Chicago Ophthalmologist, received the American Academy of Ophthalmology annual honor award for outstanding service to his profession. **John B. O'Connell, Jr., M.D.**, a fellow in the cardiology section at Loyola University Medical Center in Maywood, received the Illinois Society of Internal Medicine Norris L. Brookens award, which is awarded each year to an outstanding internal medicine resident. **Roman W. Kozakiewicz, M.D.**, a Chicago physician on the staff of Saint Mary of Nazareth Hospital Center, was recently named a fellow of the American Academy of Family Physicians.

The American College of Cardiology recently announced the names of 19 Illinois cardiology specialists who have been awarded the status of Fellows in that organization. The new fellows are **Emanuel R. Arbel, M.D.**, Chicago, **Antonio Q. Chan, M.D.**, Oakbrook Terrace, **Francis S. Cheng, M.D.**, Rolling Meadows, **Danilo A. Deano, M.D.**, Chicago, **David L. Fishman, M.D.**, Maywood, **Frank J. Forlini, Jr., M.D.**, Rock Island, **Julius M. Gardin, M.D.**, Chicago, **Madam Lal Gupta, M.D.**, Galesburg, **Hossein Keivan, M.D.**, Blue Island, **Bart R. Mayron, M.D.**, Chicago, **William L. Millman, M.D.**, Oak Park, **John P. Monteverde, M.D.**, Skokie, **Thomas E. Murphy, M.D.**, Evanston, **Paul Naffah, M.D.**, Elmwood Park, **Karoon Nititham, M.D.**, Evanston, **Gerald R. Peterson, M.D.**, Rockford, **James A. Schoenberger, M.D.**, Chicago, **Ronald L. Van Der Horst, M.D.**, Glencoe, and **James W. Ziccardi, D.O.**, Chicago.

APPENDECTOMY LINKED TO LARGE BOWEL CANCER—Results of a study conducted at the University of Texas M. D. Anderson Hospital and Tumor Institute reported at the 12th International Cancer Congress in Argentina have hypothesized a correlation between cancer of the large bowel and previous appendectomy. The study, conducted by the National Large Bowel Cancer Project, found that of 917 patients treated for colon and rectal cancer during the period 1963-73, 35% had had prior appendectomies. (The general population has a 15% incidence of appendectomy). In reporting results, Birger Jansson, a biomathematician associated with M. D. Anderson who coordinated the study, said, "Many persons have the appendix incidentally removed during other types of abdominal surgery . . . such non-indicated removal should be questioned."

DANGEROUS DRUGS UPDATE—The Illinois Dangerous Drugs Commission voted at the October 20, 1978, meeting to add pentazocine (Talwin) to the list of designated products in Illinois. This decision, which took effect November 10, requires that all prescriptions for pentazocine be written on the official triplicate prescription form. The Commission had voted at their August meeting to designate pentazocine as a Schedule II substance.



Disapprove Concept, Not Method

Blue Cross/Blue Shield's unsuccessful bid to attach a "medical necessity" rider to its policies has focused attention on the ill-advised concept of retrospective review by carriers to justify denial of payments.

Following state Insurance Department "disapproval" of the controversial rider, the Senate Insurance Committee last month held public hearings on the issue and the Department's approval process for all riders. The hearing raised some disturbing points.

"Disapproval" was a victory for ISMS which led the storm of protest that prompted Insurance Department action on the rider which would have denied payment for services the carrier deemed not medically necessary. However, at the hearing it was strongly suggested that the method of applying retrospective denial—not the concept itself—was improper. If an acceptable method of application had been used, the rider might have remained in effect.

Regardless of how it is applied, retrospective denial contains an inherent unfairness to both physician and patient. When payment is denied after-the-fact, a patient logically can be expected to question the prescribed treatment. Subsequent damage to the physician-patient relationship could be irreparable. In addition, this type of review places the patient at risk for conceivably greater expenses.

Carriers seem bent on ignoring the effectiveness of concurrent review carried out in all hospitals by Utilization Review (UR) committees. Because the entire staff has an opportunity to participate, UR serves as an educational as well as cost control process. UR is undeniably a peer review procedure. The same cannot be said for retrospective review by physicians who work for insurance carriers but do not practice medicine.

Hospital utilization review—required under PSRO in Cook County—has proven effective. A retrospective review by Blue Cross/Blue Shield of concurrently-renewed, PSRO-approved cases uncovered an incidence rate of only one in 10,000 that did not meet the carrier's criteria.

The benefits of concurrent review over the retrospective approach are obvious. The concept of retrospective denial—not the method of applying it—should be the basis of "disapproval."

A handwritten signature in dark ink, appearing to read "David S. Fox". The signature is stylized with a large initial 'D' and a cursive 'F'.

David S. Fox, M.D., President

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EMERGENCY DEPARTMENT PHYSICIAN: Become part of an expanding, dynamic multispecialty clinic in midwest university community of 100,000. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801, (217) 337-3239.

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ILLINOIS—PEORIA—Interviewing career Emergency Physicians for full-time openings starting immediately and Jan. 1. Opportunity to join young ACEP oriented physicians' group in 550-bed Medical-Surgical Hospital affiliated with Peoria School of Medicine. Good specialty backup. Flexible scheduling. Superior compensation with liberal fringe benefits including malpractice. Contact H. T. Stratton, M.D.; Methodist Medical Center, 221 NE Monroe, Peoria, IL 61636; (309) 672-4974 or (309) 672-5501.

PHYSICIAN WANTED. Full or part time for fully equipped medical center. Large welfare practice. 2823 N. Clybourn, Chicago, Ill. 60618. Telephone—(312) 929-6999 or 664-3157.

OCCUPATIONAL MEDICINE—National corporation needs associate medical director in Skokie, Illinois; occupational medical experience desirable. Corporation dedicated to comprehensive health program for all employees; modern well equipped facilities; liberal fringe benefits include life and health insurance, excellent savings plan, malpractice insurance coverage, liberal vacation, holiday and sick leave policies, etc.; salary commensurate with position responsibilities, experience and professional training. Send resume in confidence to Box 935, c/o Illinois Medical Journal. An Equal Opportunity Employer.

PHYSICIAN WANTED: General medical services to be provided to psychiatric patients. Full and part-time positions available. Generous fringe benefits. Salary negotiable. 50 minutes from downtown Chicago. Contact Claude Roush, Superintendent, Manteno Mental Health Center, Manteno, Illinois 60950. (815) 468-3451.

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IN PATIENT CLINIC PRACTICE at Illinois Developmental Centers; various locations. Monday through Friday, days only, no night or weekend call. Guaranteed income of \$40,000-\$50,000. Send CV to T. P. Cooper, M.D., 970 Executive Parkway, St. Louis, MO 63141, or call toll free 1-800-325-3982.

ORTHOPEDIC SURGEON who desires to locate in a rural area of southern Illinois needed to serve two community hospitals. One hour from St. Louis. Good educational system for children. Excellent recreation. Reply: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263.

A PROGRESSIVE RURAL COMMUNITY in midwestern Indiana desires to secure two or more general practitioners. Interested parties would find new schools, a new nursing home, new banks, good hospitals nearby, etc. A medical center with purchase option will be built to accommodate these physicians. Contact J. D. Piech, 1600 E. Liberty, Covington, Indiana. (317) 793-4818.

ILLINOIS DEVELOPMENTAL CENTERS: Background in primary care and psychiatry helpful; Interdisciplinary team approach. Monday-Friday, days only, nights or weekends optional; excellent remuneration; Illinois license required. Contact T. P. Cooper, M.D., 970 Executive Parkway, St. Louis, MO 63141 or call toll free 1-800-325-3982, ext. 213.

NEEDED: Creative physician educator to assume an excellent position and opportunities as Associate Director of a Family Practice program which is part of a 30 physician residency. This center is located within the new Medical Tower adjacent to an 1150 bed teaching hospital in Indianapolis, Indiana. Excellent salary and benefits available. For further information, send C.V. to: Director of Family Practice Education, Methodist Hospital, 1604 North Capitol Avenue, Indianapolis, Indiana 46202.

FAMILY PRACTICE SPECIALIST NEEDED in busy expanding, future oriented, multispecialty clinic to participate in development of new department; three department members plan curriculum for AAFP approved family practice residency; ample opportunity for developing, fulfilling, primary practice and personal development; located in university community; liberal financial and fringe benefits. Contact: Medical Director, Carle Clinic, Urbana, IL 61801. (217) 337-3239.

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OPPORTUNITIES FOR PHYSICIANS IN CHICAGO WESTERN SUBURB: Unique new medical office condominiums under construction in Wheaton/Carol Stream. Anticipated occupancy February, 1979. Opportunity to lease, purchase or lease with an option to purchase. Situated adjacent to existing Professional Park housing 35 physicians. Call (312) 665-9777 for details or brochure.

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I.S.M.S. GUARANTY FUND (\$6840.00) Certificate discounted for sale. Class 4, territory I, number 7340, \$1,000,000.00/\$1,000,000.00. Sale price: \$5130.00. Contact Sandra (312) 442-6500 Ex 233.

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ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE Guaranty Fund Certificate for sale. Territory I Class 1. Purchase price \$772. Best offer. Contact Dr. Moran at (312) 425-8000 Ext. 5566.

WILL BUY Guaranty Fund Certificate, Illinois State Medical Inter-Insurance Exchange, from retiring or departing physician. Contact Mrs. Yost (312) 596-7070.

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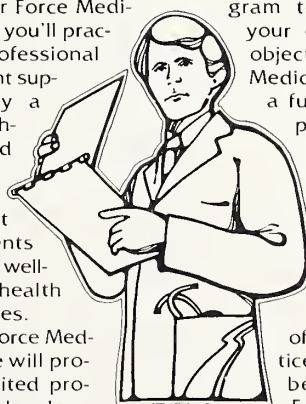
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report

Illinois Society
American Association of Medical Assistants

Cook County Regional Meeting

"THE UNDETECTED DISEASE"

John Kelly is a 22-year-old male who lives at home with his family. His mother has called the office on many occasions to confide in the medical assistant about her son. She wants an appointment for John because something just isn't right, but she can't put her finger on it. She says he's lost weight and hasn't any desire to eat. There are many changes in his personality and she just doesn't seem to know her son anymore. Many appointments have been made for John, for all of which he has been a no-show. When follow-up calls were made to the patient regarding this, his personality revealed hostility. Several months later the patient comes to the office and can't understand why he needs to be seen by a doctor. His attitude is very negative and despondent.

John Kelly is a fictitious person. He was developed to help illustrate characteristics of potential drug or alcohol abusers. Have you had a John Kelly in your medical office? What signs do you look for in a patient that could lead you to believe he or she could be a possible drug or alcohol abuser? When this person is identified, what types of help are available? How many good referrals are you aware of? What kind of encouragement are you able to extend? Is counseling available for the family as well?

On Sunday, November 19, 1978, an all day meeting will be held at the Civic Center, 1420 Miner Street, in Des Plaines. The main objective of this gathering will be early detection and

referral for drug and alcohol abusers.

Robert O'Neill is the Safety Education Officer at the Des Plaines Police Department. He will be presenting the drug problems in the community and how to deal with them in our youths. He will be giving information on street names of drugs, showing what they look like and how they are used. A film will be shown entitled, "Dead is Dead."

Ronald Melka is a Youth Advocate from Youth in Crisis. He has his B.A. in Psychology and Sociology. He also has been a volunteer trainer in drug crisis management for 2 years. He will be dealing with the types of counseling and referrals.

Mr. F. remains anonymous. He is a member of Alcoholics Anonymous. His presentation will be of his life experience and emotional aspects of the disease. He will show us the correct way to ask a case history and he will be showing a film endorsed by Bell Telephone called "Guidelines."

Registration after November 1, 1978, is \$4.00 for AAMA members and \$6.00 for non-members. The program is free to students. This knowledge will be a benefit for you in or out of the medical office. For a printed brochure or more information call or write Program Coordinator Cheryl Hurley, 312/960-4239, 547 Brookside Drive, Westmont, IL 60559, or Registration Chairman Mary Bouzoukis, 28 King Arthur Ct., Northlake, IL 60164.

COMPATIBILITY



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert same stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 µg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon. See package insert for complete prescribing information.

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Resident Physicians Comprise 36% of New ISMS Members

BY LINDA L. HUGHEY, M.D./WILMETTE

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

Since January 1, 1978, 221 of 621 new ISMS members have been residents. Thus 36% of all new ISMS members since the first of the year have been resident members. Illinois, with 1,051 resident AMA members, ranked second only to New York State (2,204 resident AMA members) in 1977.

The membership success in Illinois can be attributed to two things: a supportive state medical society structure and an active Resident Physician Section. The Illinois State Medical Society grants residents a reduced dues as well as resident seats on the major councils. The state society offers residents many benefits from group insurance, seminars, and publications. The ISMS Resident Physician Section is a recognized group with bylaws and a budget based upon Resident membership in the state society.

Building a strong base of young physicians knowledgeable about State Society structure and concerns can only benefit the state medical societies. In California the state society has gone so far as to recognize the residents as a separate "county" from the standpoint of representation at medical society functions. While Illinois has chosen to have residents affiliated via their local chapters, we as residents must realize nonetheless that the ISMS offers a great deal of support to resident members. And the residents have responded by supporting the ISMS with new memberships.

DOCUMENTATION AT LAST RESIDENTS ARE INDEED COST-EFFECTIVE

Hartford Hospital hired an independent auditing firm to determine the hospital cost of main-

taining services without educational programs. In other words, did residents and nursing students provide services which were worth more to the hospital than the total cost of the educational programs involved in their training programs? It should come as no surprise to most residents that the auditing firm found residents and other trainees more than pulled their weight: the operating budget would have to be increased to provide similar services in the absence of residents. Even after granting generous allowances for residents being "less efficient" than staff physicians (which a study in *Journal of the American Hospital Association* grants is a questionable assumption) the cost of hiring physicians to perform resident functions outstripped the costs of resident education.

This information is hardly surprising to residents who are able to add together the amount their hospitals can bill patients for the services rendered by residents. But the Hartford study (*JAHA* 47: 65-74, March 1, 1973) by Drs. Freymann and Springer, might be useful to residents negotiating contracts. Residents may be considered "students" but they pull their own weight in keeping their hospitals solvent.

AMA RESIDENT PHYSICIANS SECTION INTERIM MEETING

The AMA-RPS Interim Business Meeting will be held December 1-2 in Chicago. The meeting will include workshops and speakers of general interest, social gatherings as well as the RPS Interim Business Meeting. Details and a schedule of events can be obtained from the AMA Department of Housestaff Affairs, 535 N. Dearborn St., Chicago 60610 or 312-751-6000.



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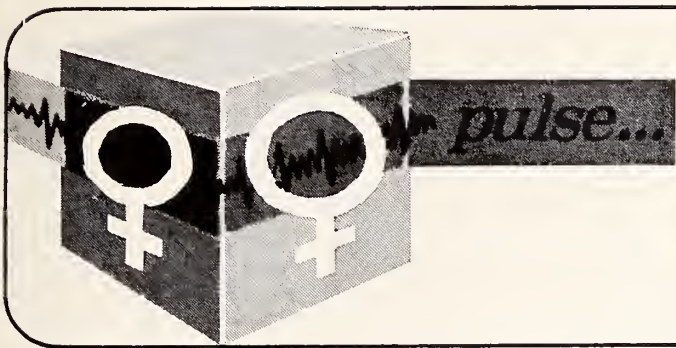
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MRS. EUGENE VICKERY, Editor



Growth Patterns

News From Around the Counties

MRS. EARL V. KLAREN, PRESIDENT, ISMSA

Adams County Auxiliary Approaches 40 Years of Community Service

Since 1939, when the Adams County Medical Society Auxiliary was founded, its members have been involved in a wide variety of community service projects. In 1942, ACMSA was featured in Life Magazine for assistance given the American Red Cross blood donor program. Since that time, members have been responsible for nurse recruitment programs, a Homemaker Health Aide Service, World Medical Relief Programs and many AMA-ERF projects. Last year, ACMSA concentrated on immunization programs, painting the "Immunization Hopscotch" on school playgrounds.

This year's project in Adams County is a two-pronged attack on child health issues: scoliosis screening and nutrition education in the schools.

Public Health and Safety Projects Reported from Morgan-Scott County

The Morgan-Scott Medical Society Auxiliary was formed in October of 1964. In the ensuing years, their numbers grew from three to thirty-two active auxiliaries, who can boast many projects of enduring importance.

Morgan-Scott efforts have included a number of educational campaigns focused on lay persons confronted with medical emergencies, pamphlets giving access information to emergency services, and distributions of water safety materials. Other efforts have included projects for AMA-ERF, distributions of posters describing the a maneuver to prevent food choking, and fund-raising for HOPE and the ISMS Benevolence fund.

Last Year, Morgan Scott initiated their first International Dinner, an effort to extend friend-

ship to new physicians' wives, particularly those from foreign countries. Members plan to continue the dinners as a special tradition, and are enthused about prospects for another year of community education and service.

Stephenson County Gains National Recognition

A telephone book listing of health care and social services compiled by members of the Stephenson County Medical Auxiliary was recently lauded by the Department of Health, Education and Welfare as a "novel concept in human services."

In 1975, SCMA compiled a full-page listing of contact access numbers for persons in Stephenson County. The list touched upon such needs as ambulance services, organizations for handicapped persons, sources of freely loaned medical equipment, and mental health adjunct groups. That listing has been published in the local telephone book each year, undoubtedly resolving countless crises.



Stephenson County's projects received special attention at state convention this year, when they were given the annual Achievement Award. Pictured above, 1977-78 President Esther Lopez proudly displays their plaque.

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*Please see complete prescribing information, a summary of which follows.

DESCRIPTION:

Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:

Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
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EKG

(Continued from page 336)

Answers: 1. A. B. 2. E.

A careful examination of the rhythm strip at rest shows a short PR interval of 0.10 seconds and a small delta wave. This man had the ECG of the Wolff-Parkinson-White syndrome. The ST segment starts to depress at six minutes of exercise and is depressed more than one millimeter with an upsloping ST segment contour at eleven minutes. This is an abnormal ST segment in exercise. However, Wolff-Parkinson-White syndrome is a well known cause of false-positive exercise tests. In the case of the Wolff-Parkinson-White syndrome, ST segment depression does not suggest ischemic heart disease. As further support for this, the ECG strip marked recovery

(REC), shows an alternating Wolff-Parkinson-White syndrome. Note that the beats with a delta wave and a short PR interval have a depressed ST segment while the beats with a normal PR interval of 0.14 seconds have normal ST segments. In this strip, the heart rate is regular at 96 beats per minute. This could also be interpreted at 2:1 Kent bundle block since the delta wave only appears in every other beat. No premature beats were seen. None of the management choices are indicated. An age adjusted maximal target heart rate for this 45 year old man would be 175 beats per minute. His maximal heart rate of 130 beats per minute is only 74% of the target heart rate although he exercised over eleven minutes. He was allowed to begin a walking and jogging program to a maximal heart rate of approximately 105 beats per minute and 20 to 30 minute sessions for the first month.

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When the somatic symptoms
are there but the signs
of organic disease are not
it could be the message
of psychic tension



for prompt, dependable
relief of psychic tension and
its somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjuctively in skeletal muscle spasm due to reflex spasm to local pathology, spastically caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjuctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of

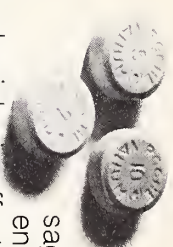
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ated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over sedation.

Side Effects: Drowsiness, confusion, ataxia, hypotension,



You've often seen the message of psychic tension: anxiety-enhanced CNS activity, resulting in physiologic effects that produce the somatic symptoms the patient complains about. Although your workup reveals no organic cause, the patient may still be convinced that he has a serious disease.

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Valium works promptly and dependably to reduce excessive psychic tension. Often, your patient feels calmer within hours and within days response is both pronounced and sustained. Equally important, Valium is usually well tolerated. Side effects more serious than drowsiness, fatigue and ataxia are rare. Of course, as with all CNS-acting agents, patients on Valium should be cautioned against drinking alcohol or operating dangerous machinery. Periodic reassessment of therapy with Valium is also recommended.

rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjuctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjuctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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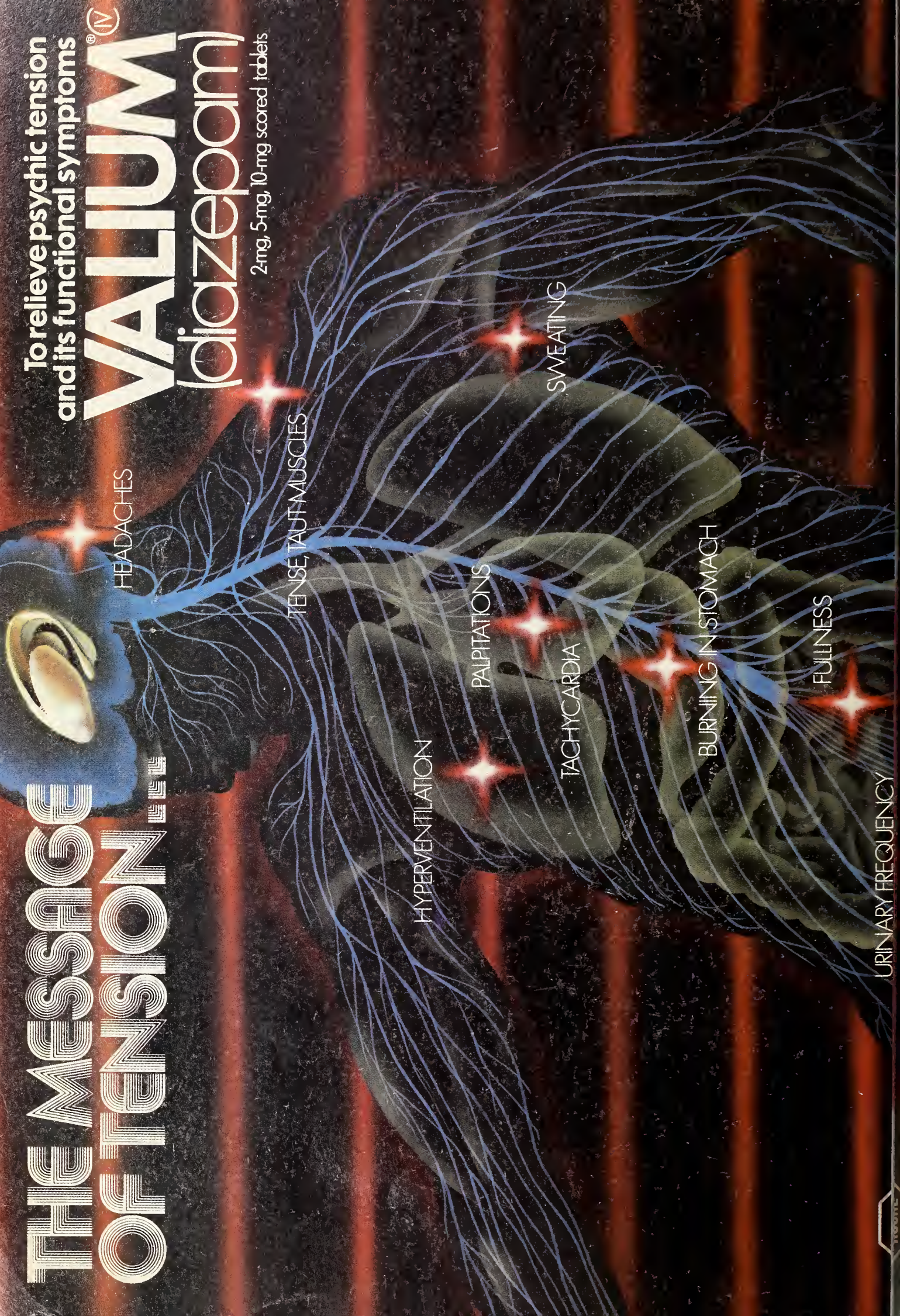
TACHYCARDIA

SWEATING

BURNING IN STOMACH

FULLNESS

URINARY FREQUENCY



Illinois Medical Journal

OFFICIAL JOURNAL OF THE
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154, NO. 6/DECEMBER 1978

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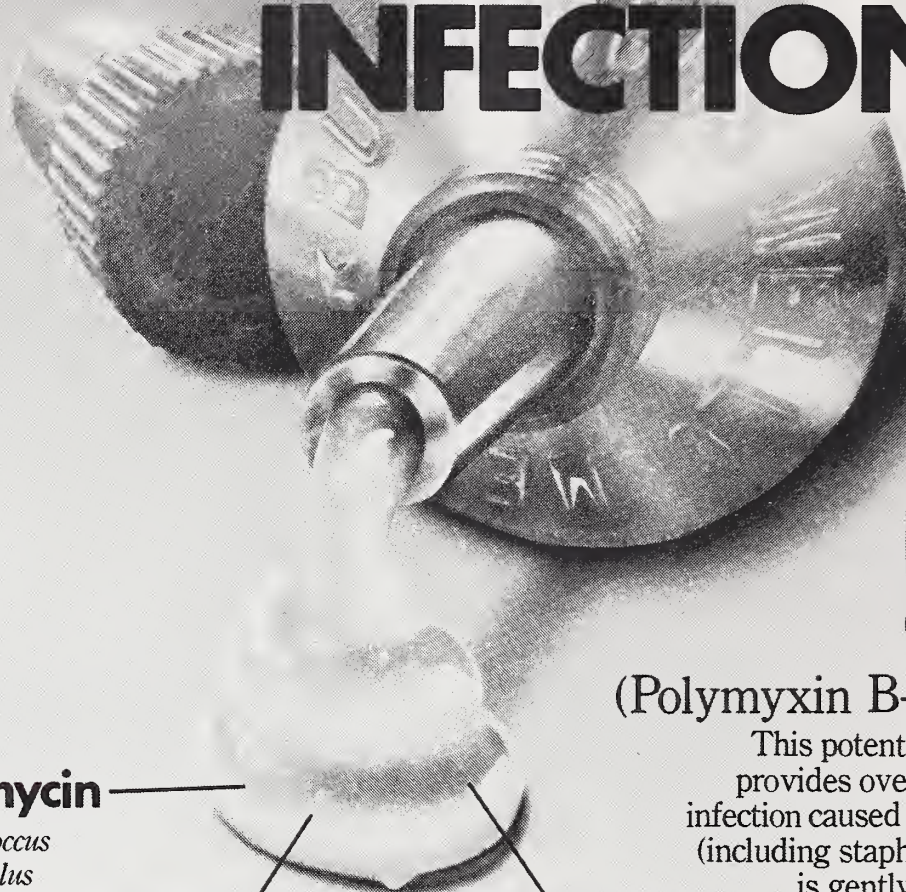


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This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

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In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).



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(Polymyxin B-Bacitracin-Neomycin)

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Clinics for Crippled Children Listed for January

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be special clinics for children with cardiac conditions and children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- January 2 Park Ridge Cardiac—Lutheran General Hospital
- January 3 Hinsdale—Hinsdale Sanitarium
- January 4 Effingham—St. Anthony Memorial Hospital
- January 4 Lake County Cardiac—Victory Memorial Hospital
- January 5 Division Cardiac—U. of I. at the Medical Center
- January 8 Peoria Cardiac—St. Francis Hospital
- January 9 East St. Louis—Christian Welfare Hospital
- January 9 Quincy—Blessing Hospital
- January 10 Champaign-Urbana—McKinley Hospital
- January 10 Chicago Heights General—St. James Hospital
- January 10 Joliet Clinic—St. Joseph's Hospital
- January 10 Cairo—Public Health Department
- January 11 Springfield—St. John's Hospital
- January 11 Macomb—McDonough District Hospital
- January 12 Chicago Heights Cardiac—St. James Hospital
- January 15 Maywood—Loyola Medical Center
- January 16 Belleville—St. Elizabeth's Hospital
- January 16 Decatur—Decatur Memorial Hospital
- January 16 Rock Island—Moline Public Hospital
- January 17 Springfield P.N.—St. John's Hospital
- January 17 Centralia—St. Mary's Hospital
- January 17 Evergreen Park—Little Company of Mary Hospital
- January 18 Elmhurst Cardiac—Memorial Hospital of DuPage County
- January 18 Rockford—Rockford Memorial Hospital
- January 19 Kankakee Cardiac—St. Mary's Hospital
- January 22 Peoria Cardiac—St. Francis Hospital
- January 24 Chicago Heights General—St. James Hospital
- January 24 Elgin—Sherman Hospital
- January 24 Mt. Vernon—Good Samaritan Hospital
- January 26 Chicago Heights Cardiac—St. James Hospital
- January 30 Alton—Alton Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Librax®

Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

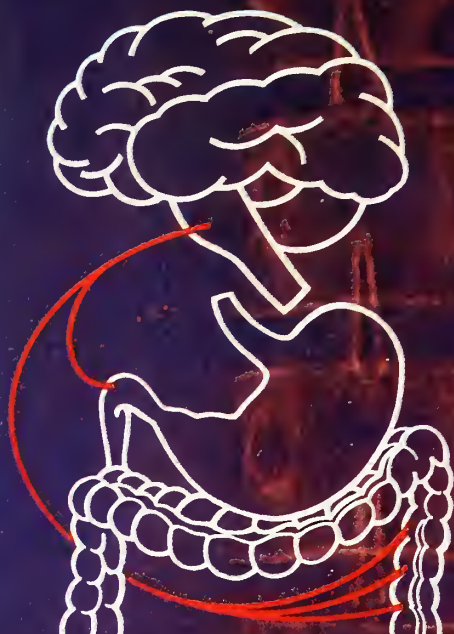
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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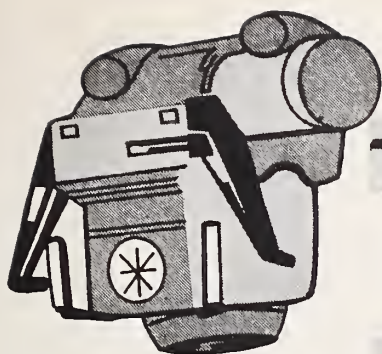
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Librax is unique among G.I. medications
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of irritable bowel syndrome* and duodenal ulcer.*

ROCHE

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's VIEWBOX was submitted by Robert E. Henkin, M.D., Associate Professor of Radiology, Director of Nuclear Medicine, Loyola University Medical Center, Maywood, Illinois.

This 31-year-old white male has recently been experiencing shortness of breath. His chest X-ray and representative images from a gallium-67 citrate scan are provided.



Figure 1

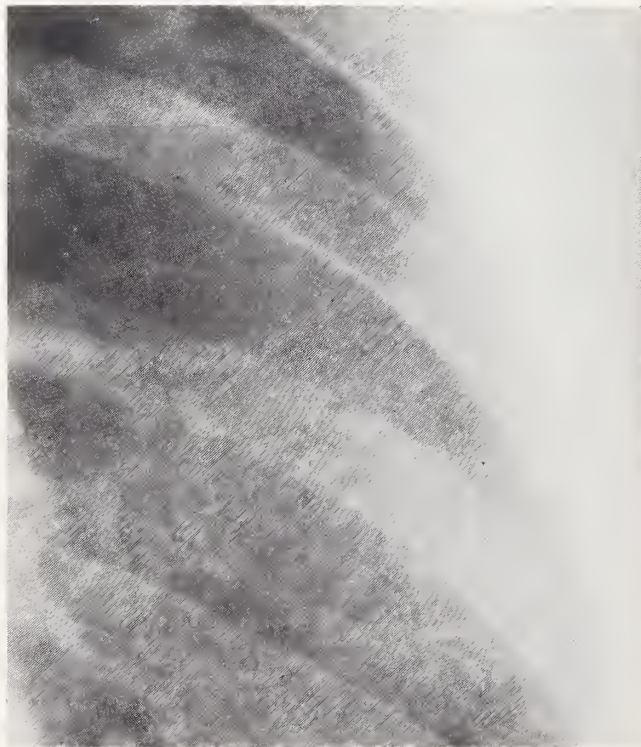


Figure 2

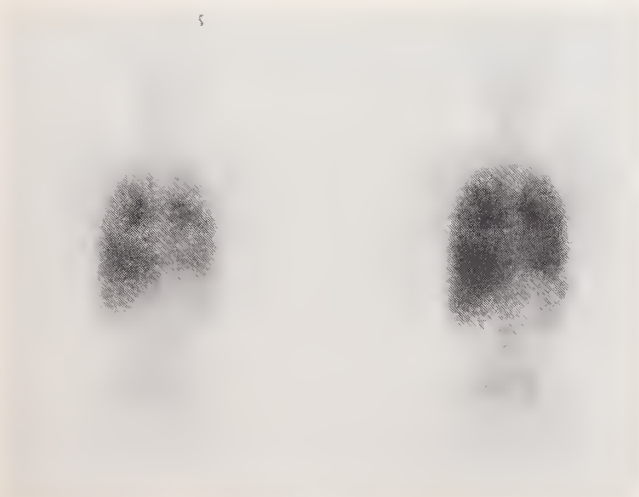


Figure 3

What's your diagnosis?

1. Carcinoma of the lung
2. Malignant lymphoma
3. Viral pneumonitis
4. Sarcoidosis

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Abstracts of Board Actions

November 3-4, 1978

Rockton

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Legal Action

ISMS will file an amicus curiae brief in a case involving confidentiality of hospital staff committee records. The brief—aimed at protecting the immunity statute which ISMS fought to enact—will be filed during appeal of a lower court ruling which held that testimony presented to in-hospital staff committees is confidential and inadmissible in court and the person providing the testimony is immune from civil liability.

In actions involving malpractice litigation, the Board voted to:

- Explore options available to assist in an appeal of the highly-publicized malpractice countersuit of Dr. Leonard Berlin. An appellate court recently reversed Dr. Berlin's lower court victory on the grounds that Dr. Berlin did not state a cause of action. The suit is based upon the theory that lawyers have a duty to those they sue and the general public as well as their clients. It was the first time in the nation that a trial court accepted the argument. The case could "break new legal ground" in countersuits. Dr. Berlin will petition the Illinois Supreme Court and possibly the U.S. Supreme Court to review the case on constitutional grounds.
- File an amicus curiae brief and provide support and technical assistance if a physician's countersuit—based upon malicious prosecution—is appealed. The brief would focus on Illinois case law which now requires that special damages be proved in order to sustain a charge of malicious prosecution.
- File an amicus curiae brief in an appeal of a lower court decision that would challenge the respondent in discovery rule. ISMS will focus on abuse of the rule and also question its constitutionality. Under the rule, the respondent, in some respects, is treated as a defendant—although not named in the suit—and there is considerable risk that his constitutional rights may not be protected.

AMA Dues Billing

ISMS will meet with AMA representatives to seek an increase in the dues remittance paid to state societies for shared distribution with those county societies who do their own dues collection. Last June, the Board endorsed the AMA Criteria for Dues Billing and Remittance—outlining a rebate formula tied to early submission of dues—which qualified ISMS for a new reimbursement rate which it planned to share on a 50-50 basis with component societies involved in the billing and collection process. However, reports indicate that the proposed rate is insufficient to attract submission of early dues.

Legislation

During the upcoming General Assembly session, ISMS will seek legislation dealing with these aspects of malpractice litigation:

- *Statute of Limitations:* Prohibit the filing of a suit more than two years after the date of the alleged act, except that a minor under the age of six would have until his eighth birthday to file.

(Continued on page 424)

**Blue Cross®
Blue Shield®**



REPORT

FOR *Illinois Physicians*

Health Care Achievement Awards Given At Symposium

Nine Health Care Achievement Awards for outstanding accomplishments in the private health sector were presented by Blue Cross and Blue Shield at its third annual symposium, "Private Initiatives in Health Care," held November 15, 1978 at Hyatt Regency in Chicago. The symposium, which also featured nationally prominent speakers, attracted over 650 guests.

Honored were health care providers, physicians, businesses and associations that have made significant progress in the areas of cost containment, quality and accessibility. The awards program was inaugurated by Blue Cross and Blue Shield to call attention to exceptional achievements in these critical areas.

Award winners in the Physicians' category were Drs. George T. Mitchell and Eugene P. Johnson. The two physicians were instrumental in development of two comprehensive medical centers in Clark County. The program was implemented at a time when the area was faced with a loss of doctors and a lack of adequate health services. The Cork and Casey Medical Centers were opened in conjunction with two extended care facilities. The centers, where the two physicians serve as solo practitioners, attracted new doctors, nurses, dentists and other professionals to Clark County.

Other winners were:

PREPAID GROUP PRACTICE—Abraham Lincoln HMO. The downstate HMO in Lincoln became fully operational in 1974 and now serves 1,614 members in Logan County. The HMO offers an extensive benefit program stressing outpatient and preventive care services with an estimated savings of \$175,000 for its members. The HMO has attracted new physicians to the central Illinois area.

GROUP PRACTICE—Occupational Health Services. OHS of Rockford is a joint venture of health care providers that offers professional, physical and emotional care to northern Illinois employers. Employers utilize OHS as a central source of comprehensive services for employees. The program is designed to help employers maintain a healthful

work environment; facilitate placement of employees; provide care and rehabilitation of occupationally ill and acutely injured employees; and assist in providing measures for personal care.

TEACHING HOSPITALS—Illinois Masonic Medical Center. The center was cited for development of an alternative birthing center in its labor and delivery/postpartum department.

LARGE COMMUNITY HOSPITALS—St. Francis Xavier Cabrini Hospital. The hospital was honored for its city doctor program which was launched when the facility faced a dwindling physician population, declining admissions and mounting deficits. Fourteen physicians were provided with offices and, in return, they referred in-patients to Cabrini. The result has been improved health care for area residents and an increase in the hospital's occupancy rate from 63 to 82 percent.

SMALL COMMUNITY HOSPITALS—Perry Memorial Hospital. The hospital dealt with the excess bed issue by achieving a 40% reduction to 105 beds in 1976. In addition, it helped develop an ambulatory care facility.

BUSINESSES—United States Steel Corporation Steel Works. U.S. Steel South Works was cited for establishment of a counseling center to provide confidential, personalized, professional services free of charge to any employee or member of their family.

ASSOCIATIONS—Illinois Health Improvement Association. The HIA was cited for its scholarship and medical student loan fund. The downstate organization has made loans and scholarships totaling \$120,000 in the last five years.

ASSOCIATIONS—River Bend Ambulance Association. The ambulance association was honored for dealing with a lack of adequate mobile emergency care in the Fulton-Albany area. The nonprofit group raised \$11,000 locally and received a grant to launch a new ambulance service. It now has 16 members and provides service that is no more than five minutes away from any emergency situation in the area.

INFORMATION ON MEDICARE PART B

Coverage of Hydrophilic Soft Contact Lenses

Reimbursement may be made under the prosthetic device benefit for the following hydrophilic soft contact lenses when prescribed on or after the dates shown for the aphakic patient:

Lens	Manufacturer	Effective Date
Softlens (polymacon)	Bausch & Lomb, Inc.	March 18, 1971
Hydrocurve (hefilcon A)	Soft Lenses, Inc.	April 30, 1974
Naturvue	Milton Roy, Inc.	May 5, 1976
Tresoft	Alcon Laboratories, Inc.	Feb. 18, 1977
Tri Pol 43 (deltafilcon A)	G and S Lens Company	April 27, 1978
Softcon (vifilcon A)	Warner-Lambert Company (American Optical Corp.)	June 30, 1978
Amsof (deltafilcon A)	Lombart Lenses, Ltd.	June 30, 1978

Hydrophilic soft contact lenses are not covered when used in the treatment of nondiseased eyes with spherical ametrophea, refractive astigmatism, and/or corneal astigmatism. Lenses can only be covered when used as a prosthetic device.

Coverage of Hydrophilic Soft Contact Lens for Corneal Bandage

When used as a moist bandage in the treatment of bullous keratopathy, payment may be made for either the Softcon (vifilcon A) corneal bandage lens produced by Warner-Lambert Company (effective with respect to services furnished on and after August 2, 1973) or for the soft contact lens produced by Bausch & Lomb, Inc. (effective with respect to services furnished on and after March 13, 1975). To be covered as a supply incident to a physician's service, the lens must have been applied and removed by the physician billing for the lens.

Changes in Participation and Certification of Laboratory Procedures

Notices were received from the Medicare Bureau of the following changes in approved tests and procedures of laboratories in the Medicare program:

Holleb Laboratory, Inc., 924 Waukegan Road, Glenview, Illinois 60025 (Provider Number 14-8114) has been approved to perform Procedure 110-Bacteriology, effective August 25, 1978. The laboratory had previously been approved to perform Procedures 200-Serology; 310 Chemistry Routine; 320-Clinical Microscopy; 400-Hematology; 710-EKG Services.

Garco Medical Laboratory, 935 W. Belmont Ave., Chicago, Illinois 60657 (Provider Number 14-8221) is no longer performing Digoxin testing under Procedure 330-Chemistry Other. Effective deletion date is December 1, 1978. The laboratory is approved to perform Procedures 110-Bacteriology; 130-Parasitology; 200-Serology; 310-Chemistry Routine; 320-Clinical Microscopy; 510-Blood Group and Rh Typing; 630-Diagnostic Cytology; 710 EKG Services; 400-Hematology.

Alpha Medical Laboratories, 7110 West 127th Street, Palos Heights, Illinois (Provider Number 14-8222) has been approved for the following procedures effective August 17, 1978; 300-Chemistry; 510-Blood Group and Rh Typing; 520-Rh Titers; 610-Tissue Pathology; 630-Diagnostic Cytology. It had previously been approved for Procedures 110-Bacteriology; 200-Serology; 400-Hematology; and 710-EKG Services.

Ace Diagnostic Laboratory, 1411 W. Irving Park Road, Chicago, Illinois 60613 (Provider Number 14-8293) has been approved to perform Procedure 710-EKG Services, effective June 7, 1978. The laboratory had previously been approved to perform Procedures 110-Bacteriology; 200-Serology; 310-Chemistry Routine; 320-Clinical Microscopy; 510-Blood Group and Rh Typing; 630-Diagnostic Cytology.

Lius Medical Laboratory, Inc., 1429 W. Irving Park Road, Chicago, Illinois 60613 (Provider Number 14-8320) has been approved to perform Procedure 400-Hematology, effective September 6, 1978. It had been approved to perform Procedures 110-Bacteriology; 200-Serology; 630-Diagnostic Cytology; 310-Routine Chemistry and 320-Clinical Microscopy.

South Suburban Medical Laboratory, 2800 W. 87th Street, Chicago, Illinois 60652 (Provider Number 14-8176) is no longer approved to perform Procedure 630-Diagnostic Cytology. Effective deletion date is December 1, 1978. The laboratory is approved to perform Procedures 310-Chemistry Routine and 320-Clinical Microscopy.



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*By repeated determinations of the basal blood pressure,** and once the medical history, physical examination, including funduscopic and routine laboratory tests,† have been completed, one is usually able to exclude secondary causes and to be reasonably comfortable with a diagnosis of primary or essential hypertension.

**The National Hypertension Program Study Committee, in September, 1972, recommended blood pressures exceeding 140/90 mm Hg be regarded as excessive for adult Americans under age 50. The World Health Committee ceiling has been 160/95 mm Hg.

†Hematoocrit, urinalysis, creatinine (or urea nitrogen), triglycerides, cholesterol, uric acid, plasma glucose, serum potassium, electrocardiogram, and chest x-ray.

Please see brief summary of prescribing information on last page of advertisement for warnings, precautions, and adverse reactions.





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References:

1. Wilber JA, Barrow JS: Am J Med, 52 653-663, 1972.
2. Data on file at Boehringer Ingelheim Ltd.



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Boehringer Ingelheim Ltd.
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Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests, one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon, vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecostasia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

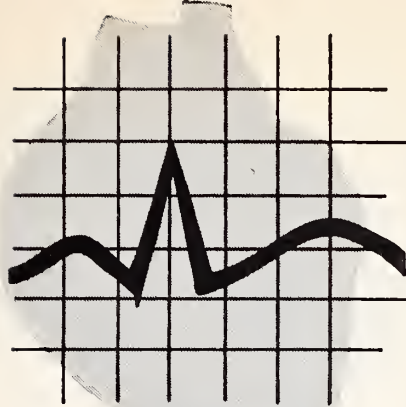
Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000.

For complete details, please see full prescribing information.

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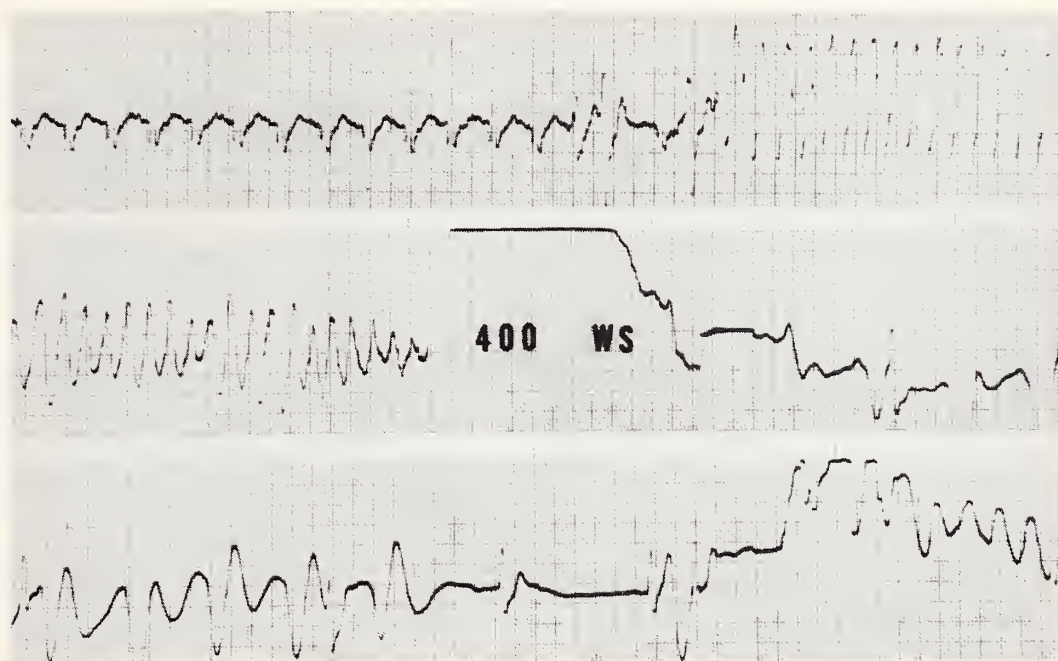
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ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D.,
PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This patient is a fifty-one-year-old man who initially presented with incapacitating angina pectoris. He had a history of an uncomplicated myocardial infarction three years earlier. Coronary arteriography was recommended and demonstrated significant proximal three vessel disease with fair left ventricular function. Open heart surgery with three saphenous vein aortocoronary bypass grafts was performed. His post-operative course was uneventful except for frequent premature ventricular beats, an occasional pair or couplet and short runs of ventricular tachycardia. He was given Procainamide in increasing doses until the ventricular irritability was eliminated. This was 500 milligrams of Procainamide every four hours. He did well and returned fourteen months later for a multistage exercise test by the method of Bruce. Unknown to his personal physician or the exercise lab physician was the fact that the patient had gradually reduced his Procainamide to the point where he had taken none at all for two months. He exercised on the treadmill for nine minutes and fifteen seconds when he collapsed. The rhythm strip shows the end of exercise and immediate recovery period.



Questions:

1. The ECG rhythm strip shows:

- A. Normal ST segment response to exercise.
- B. A pair of premature ventricular beats, or a couplet.
- C. Deteriorating ventricular flutter.
- D. A direct current cardioversion with a 400 watt-second (WS) shock.
- E. All of the above.

2. The following statement(s) are true:

- A. A large number of patients must discon-

tinue Procainamide due to a variety of toxic manifestations of the drug.

- B. Successful aorta coronary bypass surgery for severe proximal coronary artery disease does not routinely eliminate ventricular arrhythmias.
- C. Multistage exercise testing is a safe procedure. The incidence of death on the treadmill in the Minnesota survey was less than one on 10,000 tests.
- D. All of the above.

(Continued on page 449)

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Pfizer PHARMACEUTICALS

Obituaries

Breed, Thomas B., Palos Park, died in September, 1978.

***Burgert, Paul H.**, Lake Forest, died October 4, at the age of 68. He was a 1935 graduate of Northwestern University where he had also held the position of assistant professor. Dr. Burgert was president of the medical staff and chairman of the department of medicine at Lake Forest Hospital.

***Carney, John F.**, Joliet, died October 31, at the age of 60. Dr. Carney graduated from Northwestern University Medical School in 1943. He was a fellow of the College of Surgeons, affiliated with St. Joseph and Silver Cross Hospitals.

***Dailey, Paul E.**, Springfield, died November 18, at the age of 70. A 1937 graduate of the Chicago Medical School, Dr. Dailey practiced in Carrollton, and later served as consultant to the Federal Disability Program and IDPH in Springfield. He also served as Vice-President of ISMS and a member of the Illinois delegation to the AMA and the ISMS Committee on Nutrition. On the county level, Dr. Dailey held many different positions with the Sangamon and Green County Medical Societies. He also was a fellow of the American Academy of Family Practice.

Foley, Walter E., Davenport, died September 23, 1978.

Gordon, Alolphus Jr., Chicago, died September 20, 1978 at the age of 76. Dr. Gordon was a graduate of the Northwestern University School of Medicine. Prior to his death he was on the staff of Provident Hospital.

****Heller, Samuel**, Chicago, died July 17, at the age of 79. He was a 1924 graduate of the General Medical College. Dr. Heller was a staff member of Norwegian American Hospital.

Jensen, Joseph E., Laguna Hills, California, died August 26, 1978 at the age of 81. Dr. Jensen was a 1924 graduate of Rush Medical College, Chicago.

***Kampinga, Jurrien**, Chicago, died October 21, at the age of 58. He was a 1949 graduate of the University of Amsterdam.

***Koepl, Arthur**, Chicago, died recently at the age of 87. He was a 1920 medical school graduate from Wren, Austria.

***Lorber, Maurice**, Chicago, died November 7, at the age of 69. Dr. Lorber was a 1939 graduate of the Abraham Lincoln School of medicine. He was on the staff of Mt. Sinai Hospital and the faculty of Rush Medical College.

***Lusk, Frank B.**, Chicago, died October 15, at the age of 89. He was a 1914 graduate of Rush Medical College.

***Lydon, Sean B.**, Chicago, died in July, at the age of 44. He was a 1960 graduate of the University of Ireland.

****Pick, John F.**, Chicago, died October 12, at the age of 78. He was a 1925 graduate of Rush Medical College. During his medical career, Dr. Pick was affiliated with Columbus and Illinois Masonic Hospitals. He was also the chief plastic surgeon for the Army's 4th service command and for the Illinois penitentiaries from 1937 to 1965.

Reis, Ralph A., Chicago, died September 7, 1978 at the age of 82. He was a professor emeritus of obstetrics and gynecology at Northwestern University Medical School, where he had held academic posts since 1923. Dr. Reis was a 1920 graduate of Northwestern University Medical School. He served his internship and residency at Michael Reese Hospital and did his postgraduate work in Vienna and Berlin.

***Sandburg, Carl Ludwig**, Decatur, died September 24, at the age of 72. He graduated from Rush Medical College in 1941 and was a former president of the Macon County Medical Society.

***Swanson, Elmer E.**, Florida, died October 27, at the age of 88. He was a 1926 graduate of Rush Medical College and former chief of staff at South Chicago Community Hospital.

***Zurndorfer, Walter**, Florida, died August 31, at the age of 82. Dr. Zurndorfer was a 1922 graduate of the University of Wurzburg, Germany, and a former Chicagoan.

**Indicates ISMS member.*

***Indicates member of the ISMS Fifty Year Club.*

Bernice C. Uznanski, an ISMS employee for over 14 years, died on October 28. A former president of the ISMS Auxiliary, Mrs. Uznanski had served as secretary to the ISMS Committee on Drugs and Therapeutics and also administrative assistant to the Illinois Association of the Professions.

COOK COUNTY

Graduate School of Medicine

CONTINUING EDUCATION COURSES

STARTING DATES—1979

SPECIALTY REVIEW THORACIC SURGERY, January 29
SPECIALTY REVIEW NEUROLOGICAL SURGERY, February 2
CLINICAL MEDICINE, UPDATE, 5 days, March 19
NEUROLOGY, PART I, BASIC, February 26
BASIC REVIEW IN PSYCHIATRY, 5 days, March 12
SPECIALTY REVIEW SURGERY, PART II, March 12
CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC AND THROMBOTIC DISORDERS, 2 days, March 23
ADVANCES IN SURGERY, 5 days, April 9
SPECIALTY REVIEW UROLOGY, 5 days, April 9
STATE & NAT'L. BD. REV., BASIC, April 15, CLINICAL, April 23
RADIATION ONCOLOGY, 5 days, April 23
GENERAL & DIAGNOSTIC RADIOLOGY, 5 days, April 23
SPECIALTY REVIEW OBGYN, April 30
SPECIALTY REVIEW FAMILY PRACTICE, May 7
SPECIALTY REVIEW ANESTHESIOLOGY, May 13
REVIEW, MEDICAL SUB-SPECIALTIES, May 7, 14, 21

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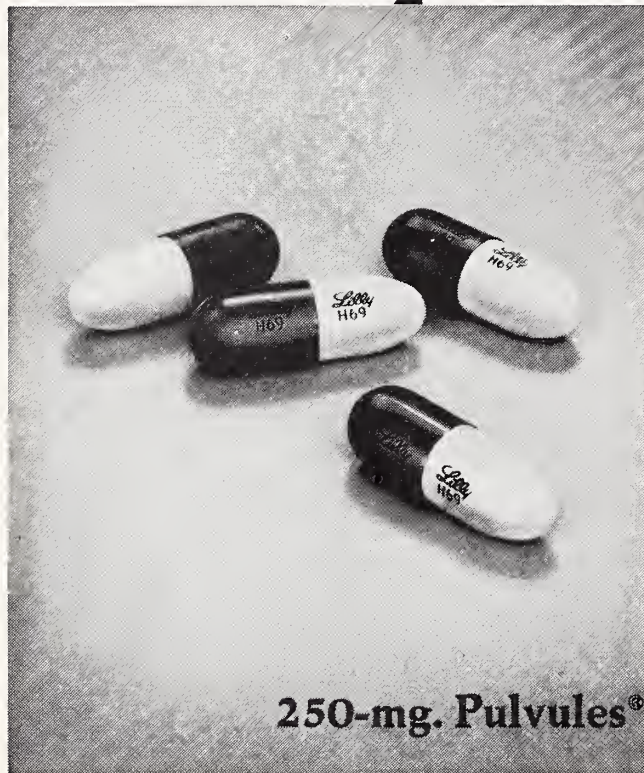
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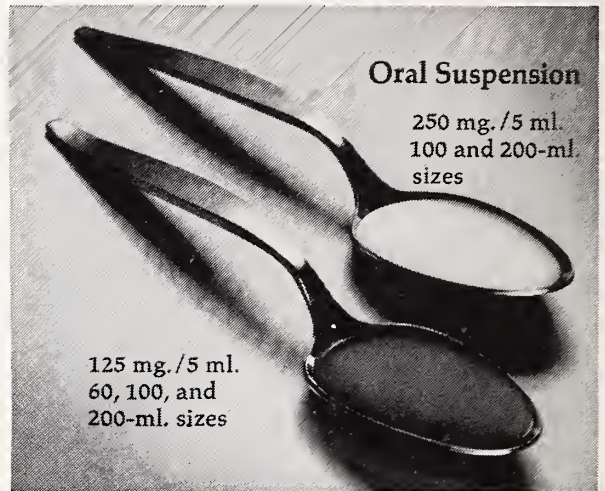
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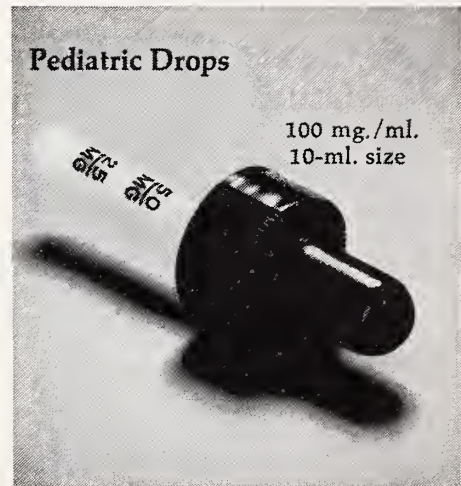
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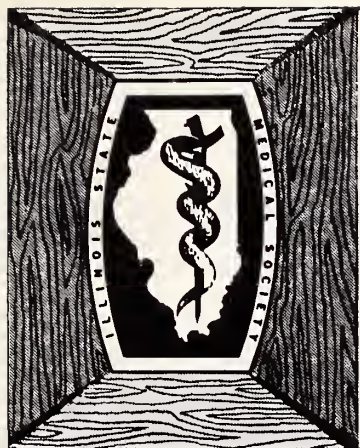
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Illinois Medical Journal

Vol. 154, No. 6, December, 1978

Seventh Case in the Literature

Scrotal Hernia Associated with Carcinoma of the Colon

BY HARRY L. MILLER, M.D., SMILJAN PULJIC, M.D., AND
HARRY GORDIMER, M.D./NEW YORK

The frequent association of colonic carcinoma in patients with inguinal hernia has often been cited.¹⁻⁵ The purpose of this paper is to report on a case of colonic carcinoma in an inguinal scrotal hernia sac. The rarity of such a lesion has prompted the report as only six other cases can be found in the literature.⁴

An 80-year-old white male was admitted to the hospital with rectal bleeding and weight loss of approximately 15 pounds over a three month period. Bilateral scrotal hernias had been symptomatic during almost his entire life. Repair of the right scrotal hernia 30 years before had not

prevented recurrence. On physical examination, he was an obese male with reducible bilateral scrotal hernias.

Upper gastrointestinal bleeding was initially suspected because of a clinical history of dark stools. However, barium enema revealed a large polypoid mass in the sigmoid colon which had herniated into the left scrotal area. The upper gastrointestinal series demonstrated a small hiatus hernia and right scrotal hernia.

At laparotomy, a well differentiated adenocarcinoma of the sigmoid colon was noted within a reducible left scrotal hernia together with peritoneal and liver metastases. A palliative resection of the left colon was undertaken with end-to-end anastomosis. Following uneventful recovery, the patient was discharged for further follow-up.

Discussion

Many authors have pointed out the frequent association of colonic carcinoma with pre-exis-



HARRY L. MILLER, M.D., is a radiologist affiliated as an associate professor with the Albert Einstein College of Medicine in New York. A diplomat of the American College of Radiology specializing in diagnostic radiology, Doctor Miller received his medical education in London, England.

HARRY GORDIMER, M.D., F.A.C.S., is a general surgeon affiliated as a consultant with the Brax-Lebanon Hospital Center and also Lincoln Hospital in New York.

SMILJAN PULJIC, M.D., is a board certified radiologist affiliated with the Brax-Lebanon Hospital Center in New York. Doctor Puljic is also an assistant professor in radiology affiliated with the New York Medical College.



Figure 1

Barium enema demonstrating an inguinal hernia with a filling defect in the herniated sigmoid due to a sigmoid carcinoma.

tent inguinal hernia.¹⁻⁵ However, in addition, the reported number of inguinal hernias in patients with carcinoma of the colon has nearly tripled.^{1,3} According to this author (John W. Maxwell, M.D. *et al.*) the appearance of an inguinal hernia may lead to a diagnosis of an asymptomatic carcinoma of the colon. In 107 of these cases (of colon lesion)³ in 1963, 17% sought medical advice for symptoms referable to an inguinal hernia. The series was enlarged to include 218 cases of carcinoma of the colon³ with 49 (22%) reporting a diagnosis of carcinoma together with inguinal hernia.

It has been stated² that a search for large bowel disease should be made when an elderly patient presents with an inguinal hernia of recent origin, recent recurrence, or recent onset of symptoms. Sigmoidoscopy and barium enema are strongly recommended in all patients over 55 years old who have been selected for elective inguinal herniorrhaphy.¹ It is generally accepted that change in bowel habits and rectal bleeding may be the first indications of colonic carcinoma, and that any sudden or recurrent intra-abdominal pressure in the elderly is a factor in the genesis of inguinal hernia.

On the contrary, Brendel and Kirsch,⁶ find a lack of association between inguinal hernia and carcinoma of the colon. In 312 patients with inguinal hernia who had pre-operative barium

enemas, no case of carcinoma was noted. Patients who had colonic cancer did not show a higher prevalence of inguinal hernia than others of the same age without carcinoma. Rogers, *et al.*,⁷ reported a case where an inguinal hernia resembled carcinoma of the sigmoid on barium enema, and suggested that the internist or radiologist should be alerted to attempt to reduce the hernia prior to performing a barium enema.

Carcinoma of the colon may cause an irreducible inguinal hernia but this is rare⁴ and due possibly to the size of neoplasm, adhesions or edema of sac contents. In a series of 23 patients with colonic carcinoma, six patients were hospitalized merely for their hernias with asymptomatic large bowel disease and no signs referable to colonic carcinoma.¹ According to the findings of Maxwell, *et al.*, in the age group between 55 and 64 years, 27.5% of the patients with colonic carcinoma had inguinal hernias, whereas, from a random questionnaire, the incidence of hernia in the general male population of that age group is 5.2%. Carcinoma of the colon can develop in a hernia and the association is more than coincidental.

Summary

A case of carcinoma of the colon presenting in an inguinal scrotal hernia with review of the literature on the subject. ◀

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Case Report

Spontaneous Pneumopericardium

BY CHARLES L. LANSFORD, M.D. AND JACK C. COOLEY, M.D./URBANA

Pneumopericardium is a rare occurrence. Shackelford's complete review of the literature² reported several causes and others have been added to this list subsequently^{1,3-5} but none of these were believed to be a late complication of surgical repair for hiatal hernia. We report such a case here.

The patient was a 54-year-old white female, registered nurse, who first presented to our clinic early in 1975, with severe left shoulder pain. Her past history revealed three upper abdominal surgical procedures to correct gastroesophageal reflux and the complications of the reflux. She first underwent a Thal repair of a strictured esophagus in 1967. A stormy postop course with high fever necessitated re-exploration in two weeks, but according to the records no source of fever was found. Dysphagia had recurred and dilations were necessary. A Nissen repair was performed by the abdominal approach seven years after the initial surgery. She was symptom free until January, 1975, when she was seen in

the Carle Clinic Rheumatology Department for left shoulder pain. When no local cause of the pain was found, esophagogastroduodenoscopy was performed but failed to reveal any signs of inflammation or abnormalities of the esophagus or stomach.

The pain was moderately severe and did not respond well to analgesic medications. A phrenic nerve block was successful in eradicating the pain, but the effects were temporary. A phrenic crush relieved the pain. In October, 1975, the patient experienced a recurrence of her left shoulder pain, as well as dyspnea. Admission chest X-ray revealed a pneumopericardium and a breakdown of her hiatal hernia repair with upward migration of

the esophagogastric junction. The possibility of an associated rupture of a pulmonary bleb into the pericardium was considered. The patient had a benign course, remained afebrile, and the pneumopericardium resolved over four days.

She returned a month later with severe dyspnea, left shoulder and precordial pain, and diaphoresis and faintness. X-rays revealed a large pneumopericardium and a crunching sound could be heard in the anterior precordial area. After an afebrile, benign course, she was taken to surgery.

Surgery

At surgery, a left posterolateral incision was made entering the pleural space through the seventh intercostal space. The pleural space was relatively free. The left lung was retracted superiorly, and this disclosed a large portion of the stomach in the chest area where the old Nissen repair had been previously carried out. The stomach wall was found on inspection to be densely adherent to the pericardium. Accordingly, a nasogastric tube was passed into the stomach

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and tapes were placed around the esophagus above and the stomach below. A two inch square area of pericardium where the stomach and pericardium were adherent was then resected. It was then possible to retract the area of the sutured Nissen repair and the pericardium from the remainder of the pericardial sac. Using a probe, a small fistulous hole could be demonstrated that connected the pericardium and the portion of the stomach above the diaphragm. This fistulous tract was carefully closed using interrupted 3.0 silk sutures. The pericardial window was left open. Multiple cultures of pleural fluid and pericardial fluid were made. A catheter was left in the pleural space for drainage, and the chest was closed in a routine fashion. The patient had a most uneventful postoperative course and was dismissed from the hospital on the ninth postoperative day. She has had no further problems with left shoulder or chest pain.

Discussion

A review of the literature reveals many causes of pneumopericardium, most reporting cases with a stormy course and eventual death.³⁻⁵ Symptomatically, most cases present as an acute catastrophe resembling myocardial infarction or massive pulmonary embolism with sudden chest or upper abdominal pain and collapse. Some demonstrate precordial tympany with shifting dullness over the precordium and mechanical splashing sounds synchronous with systoli (*bruit de roue hydraulique*).

Our case appears to be remarkable in its very benign course and in the suspected etiology: a suture-induced fistula between the stomach and pericardium. No evidence of ulceration, tumor, or previously reported cause for the pneumopericardium was found in this patient. This small size and superior location of a fistula apparently prevent-

ed solid material or significant liquid gastric contents from reaching the pericardium and thereby apparently prevented a more fulminating pericarditis.

Pneumopericardium is another potential complication of hiatal hernia repair. ◀

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High Altitude Pulmonary Edema

BY THOMAS S. KIM, M.D./ARLINGTON HEIGHTS

High altitude pulmonary edema (HAPE) has been described with increasing frequency in medical literature. This entity is ordinarily localized to high altitude geographic areas. Due to the increased mobility of modern society and rapid speed of transportation today, however, it may not be unusual to be confronted with such an entity in the Midwest. A typical case of high altitude pulmonary edema was seen during the past winter in a northwest suburb of Chicago.

A thirty-year-old Hawaiian-born male was admitted to the intensive care unit complaining of chest congestion and dyspnea. He had just flown back from Montana, where he had been skiing for two days at an altitude of eight to ten thousand feet. On the second day of skiing he became aware of extreme fatigue and dyspnea. He also noticed mild chest discomfort accompanied by cough and pink frothy sputum production. As he had experienced a similar episode approximately one year ago, the patient

decided to return home for medical attention. Within 12 hours he sought medical attention at the hospital.

Past Medical History

This patient's general medical history was unremarkable and noted no specific cardiac or pulmonary illnesses in the past. Until two years ago he had never climbed to an altitude of higher than three or four thousand feet. A year ago he had spent several days skiing in Colorado at an altitude of eight

to eleven thousand feet, and after several days had developed symptoms consisting of cough, chest discomfort and dyspnea. He was hospitalized for four days and at discharge, was told that he may have high altitude pulmonary edema. Since this episode in Colorado, the patient reported no respiratory symptoms until his most recent experience in Montana.

Clinical Findings

Physical examination revealed a young, healthy male who appeared mildly dyspneic with a respiratory rate of 26 at rest. Positive findings were confined to the chest where breath sounds were noted to be decreased with rales at the bases. Cardiac examination revealed a regular rhythm with no significant murmurs or gallops. Neck veins were flat. There was no clubbing or peripheral edema. Physical



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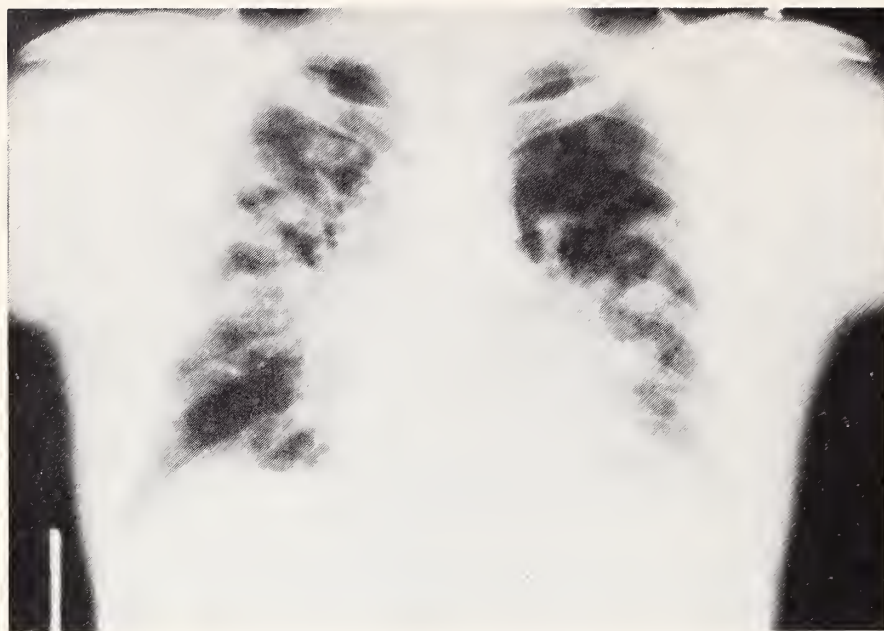


Figure 1A
Patient X-Ray on Admission



Figure 1B
Patient X-Ray on Discharge

examination was otherwise negative.

Laboratory Data

Chest X-ray at admission revealed a fluffy, patchy infiltrate bilaterally with a normal cardiac

silhouette. Arterial blood gases on room air showed a PCO_2 of 35, PO_2 of 41 and PH of 7.46 with an oxygen saturation of 80%. CBC revealed a WBC of 11,500 with normal differential; hemoglobin was 16.7 Gm and hematocrit, 50%.

MVC was 96, MCH was 31.7 and MCHC was 33.3. Serum proteins and EKG were normal.

Hospital Course

The patient was admitted to the intensive care unit where he was put to bed rest and placed on a high flow oxygen delivery system of 35% Venturi mask. His symptoms rapidly improved, along with the arterial blood gases. After three days of hospitalization he was discharged with near normal blood gases and an entirely normal chest X-ray. (See Figures 1 and 2)

Discussion

HAPE was specifically described by Houston followed by Hultgren and others who have since reported clinical and physiologic studies of this entity.^{1,2} Although the mechanism of HAPE is obscure and controversial, the clinical and the physiological data are relatively uniform. The following is a summary of the clinical and laboratory data of HAPE.

Clinical Setting

The severity and the rapidity of onset for symptoms are variable, but frank pulmonary edema usually appears within 12-48 hours after ascent to heights generally greater than eight thousand feet. It appears that young males are more susceptible than older males or females. HAPE may occur for the first time in those who have never been exposed to high altitudes as well as in those who are re-entering the high altitude areas. Those who have experienced HAPE are apparently more prone to develop this syndrome again. These patients have no pre-existing cardio-pulmonary diseases and physiologic studies usually demonstrate no abnormal findings.

Signs and Symptoms

Patients with HAPE have the usual symptoms of pulmonary edema including cough, hemoptysis, shortness of breath, dyspnea on exertion, and chest discomfort. Physical findings include rales, and cyanosis if severely hypoxemic.

Arterial Blood Gases
Figure 2

ADMISSION	FIO ₂	PCO ₂	PO ₂	PH	SAT %
1st day	Room Air	40	41	7.44	80
2nd day	35%	35	70	7.42	95
3rd day	35%	40	88	7.41	97
DISCHARGE					
1 MONTH	Room Air	41	90	7.39	98

Some patients have shown signs of acute right heart strain with right ventricular heave, accentuated pulmonary sound of the second heart sound. Neck veins are usually flat. Peripheral edema is quite unusual. They may have a low grade fever as well as leucocytosis in variable degrees. Radiologically, characteristic findings are those of a non-cardiac pulmonary edema with patches of irregular, fluffy infiltrates more commonly seen in upper and mid lung fields with no evidence of cardiomegaly. EKG is normal or non-specific. Blood gases show variable degrees of hypoxemia with arterial desaturation.

Hemodynamic findings consistently show increased pulmonary artery (PA) pressure, normal or decreased wedge pressure or left atrial pressure, normal or decreased cardiac output.³⁻⁵ More specific studies have shown that HAPE patients have diminished hypoxemic and hypercapnic ventilatory drive as compared to normals.⁶

Theories

There are many theories to explain this entity, but none so far have explained the epidemiologic, clinical, and physiologic findings to complete satisfaction. Since the most uniform physiologic finding is that of abnormally elevated pulmonary arterial pressure without increased left ventricular pressure, most theories propose to explain this phenomena.

Autopsy findings have confirmed pulmonary edema in the lungs without pneumonia or heart failure so that pneumonia, once attributed

to this entity, is now unfounded. Evidence of disseminated intravascular coagulation (DIC) has been demonstrated in post-mortem studies by some, but its role in the pathogenesis of pulmonary edema has not been clarified. Some authors have attributed pulmonary venous constriction, arteriolar constriction and nonuniform arterial veno constriction of pulmonary vasculature as a response to hypoxemia as the pathogenesis of pulmonary edema.⁷ A concept of "preterminal arteriole" has been recently proposed to explain the process of regional edema and hypoxemia, in effect causing a right to left shunting.⁸ It is apparent that none of the proposed theories fully explain the pathogenetic mechanism of high altitude pulmonary edema.

Treatment

Since the exact mechanism of pulmonary edema is not clear, therapy, to say the least, is also controversial. Probably the most important factors are bed rest and adequate oxygen therapy and descent to lower altitude for the more seriously ill. Pharmacologically, such drugs as digitalis, morphine, aminophyllin, diuretics and steroids have been advocated, but good data as to their specific efficacy is lacking. Since left heart failure has been found not to be the etiology of the pulmonary edema, most authors seem to agree that digitalization is not an important adjunct to therapy. The use of Furosemide prophylactically, especially in regard to preventing acute mountain sickness, has

been advocated by Singh,⁹ but certainly there is no general agreement as to its efficacy. Although there is no specific therapy, most patients respond well to oxygen, bed rest, and descent to a lower altitude.

Summary

In conclusion, as recreations such as mountain climbing and skiing become more popular, high altitude pulmonary edema and other associated high altitude illnesses such as cerebral edema and acute mountain sickness may be seen more frequently. In addition, due to various modes of rapid transportation today, more people are being exposed to high altitudes without being acclimatized. This also pertains to return from these areas. For this reason, HAPE may be observed in low altitude areas such as the Midwest. ◀

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Summary of Actions

1978 Interim Sessions

Of the House of Delegates

The House of Delegates took the following actions on resolutions and reports considered by:

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

1. Amended the Bylaws to delineate concerns of the Council on Medical Service as: (A) provision of medical and health services in the public and private sectors; (B) emergency medical services; (C) health care for the poor, the aged and rural residents; (D) maternal and child health; (E) nutrition; (F) workmen's compensation; (G) environmental and community health; (H) rehabilitation; and (I) health care facilities and delivery systems. (78N-17)
2. Amended the Bylaws to provide for a Board of Trustees Committee on Third Party Payment Processes to consider issues or problems requiring high-level negotiations with third-party payers. (78N-16)
3. Referred to the Board of Trustees for study a resolution which would revise the areas of concern of the Council on Economics and Peer Review. (78N-15)
4. Amended the Bylaws to create an independent Judicial Panel to handle ethical relations matters, removing that responsibility from the Board of Trustees and the Ethical Relations Committee. The five member Panel—elected by the House—will hear all appeals and adjudicate disputes on ethical affairs involving component societies, district committees and ISMS. Under the Panel system, county societies retain the option of maintaining an ethical relations committee or delegating its responsibilities to a district body. The Panel will accept appeals only after the case has been heard at the local level. Appeals based upon new evidence will be referred back to the local committee for possible rehearing. The

Judicial Panel will intervene only when a component society fails to act in a timely manner. Decisions of the Judicial Panel are final, unless an appeal is feasible under the Constitution and Bylaws of the AMA. To ensure uniformity in handling cases at all levels, the Panel will prepare for House approval a *Handbook for the Conduct of Disciplinary Proceedings*. Elected to the Panel were Drs. Howard Burkhead, Evanston, 5½ yrs., Frank Norbury, Jacksonville, 4½ yrs., Herschel Browns, Chicago, 3½ yrs., Eugene Johnson, Casey, 2½ yrs., J. Robert Thompson, Oak Park, 1½ yrs. (78N-25, 26, 27, 28, 29, 30)

5. Approved creation of a Peer Review Appeals Committee reporting directly to the Board of Trustees. The Committee will hear appeals by any party based upon bias, incomplete information, substantive or procedural error. The House also adopted the following definition of peer review:
Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical society peer review shall be conducted at the local level whenever possible. Major ethical relations questions identified during deliberations of the Peer Review Appeals Committee shall be appropriately referred. (78N-48, 49)
6. Amended the Bylaws to expand responsibilities of the Council on Affiliate Societies to include initiation of recommendations to the Board of Trustees on legislative matters affecting any specialty society. (78N-18)
7. Referred to the Board of Trustees for study a resolution intended to restrict kinds of

business to be considered at Interim Sessions of the House of Delegates. In the interest of efficiency, the resolution would permit introduction of only urgent matters at Interim Sessions. (78N-19)

8. Transferred the Tazewell County Medical Society from the Fifth to the Fourth Trustee District. This change was initiated to bring compatability to Tazewell County's HSA, PSRO and Trustee District designations. (78N-24)
9. Referred to the Board of Trustees for study a resolution to expand the duties of the Illinois State Medical Society president. (78N-47)

REFERENCE COMMITTEE "A"

1. Revised a policy statement on committee appointments to limit individual tenure on ISMS committees to a maximum of five years. (78N-5)
2. Deleted the following statements from the ISMS policy manual: (A) "Education, Primary and Secondary," (B) "Facility Medical Boards (Physicians)," (C) "Federal Funds," (D) "Relative Value," and (E) "Ethics." (78N-6, 8, 12)
3. Referred to the Board of Trustees for study a resolution to delete the statement, "Fee Schedules," from the ISMS policy manual. (78N-11)
4. Rejected a resolution to allocate one delegate and one alternate delegate position on the Illinois Delegation to the AMA to resident members. (78N-23)
5. Rejected a resolution to seek lower malpractice premiums in the interest of cost containment. (78N-20)
6. Directed the Board of Trustees to investigate the feasibility of the Illinois State Medical Inter-Insurance Exchange extending coverage to include protection of county society officers in performance of administrative duties. (78N-31)
7. Rejected a resolution mandating the Board of Trustees to report to the House on the implementation of previously adopted resolutions, noting that the intent of the resolution is being fulfilled and the additional statement was considered superfluous. (78N-35)
8. Encouraged hospital medical staffs to perform focused utilization review of all patients in selected diagnostic categories, re-

gardless of the source of payment, and further urged all third party payers (private and governmental) to reimburse hospitals and physicians for time and expense of such utilization review. (78N-40)

9. Referred to the Board of Trustees for study a resolution regarding second opinion for surgery. The resolution called upon ISMS to: (A) oppose utilization of a closed panel of consultants, favoring usual and customary referrals; (B) oppose board certification as a referral criterion; and (C) favor the use of non-surgical specialists. (78N-42)
10. Referred to the Board of Trustees for study a resolution which would require information on any proposed dues increases and assessments to be distributed to delegates and county medical societies at least 30 days prior to formal consideration by the House of Delegates. (78N-43)
11. In response to a recent statement regarding conduct by the Association of American Medical Colleges, called upon the AMA to invite the Association of American Medical Colleges to present its views on ethics to the AMA for consideration and to reiterate AMA standing as representative for all U.S. physicians. (78N-59)

REFERENCE COMMITTEE "B"

1. Approved revision in the policy manual to update statements entitled "Public Aid" and "Comprehensive Health Planning." (78N-9, 13)
2. Directed the Society to take action to prevent third party access to the physician's own private medical practice business records without appropriate legal authority assuring due process. (78N-34)
3. Directed the Illinois Delegation to the AMA to introduce a resolution supporting: (A) stronger local and state control of the health planning process and (B) appropriate amendments to P.L. 93-641 to make HSAs directly responsive to their constituent national legislators on a regular basis in matters related to HSA fund utilization, accomplishments and/or problems. (78N-36)
4. Reaffirmed ISMS opposition to compulsory governmentally mandated national health insurance plans and instructed the Illinois Delegation to the AMA to oppose introduction by the AMA of any further national health insurance legislation. (78N-60)

REFERENCE COMMITTEE "C"

1. Referred to the Board of Trustees for study a resolution regarding medical school admission criteria and physician distribution in Illinois. (78N-1)
2. Rejected as improper a proposal to delete from the policy manual the statement entitled "Nurses-Shortage." (78N-10)
3. Determined that authors or discussants at programs for which ISMS is the primary fiscal sponsor be asked to submit original papers to *IMJ* for publication consideration with the right of first acceptance or refusal. (78N-21)
4. Rejected a resolution which would have had ISMS oppose any efforts to define or classify human life. (78N-22)
5. Encouraged AMA to oppose development of any JCAH standard mandating medical staff membership to anyone other than fully licensed physicians and dentists. (78N-32)
6. Endorsed the Voluntary Effort to Control Health Care Costs, and supported the concept that physicians should help to moderate medical care costs. (78N-33, 57)
7. Rejected a resolution regarding ISMS policy on cost containment, the intent of which is fulfilled through the Task Force on Cost Effectiveness. (78N-41)
8. Referred to the Board of Trustees for study a resolution suggesting that ISMS establish a physician negotiating agency as a membership service. (78N-46)
9. Expressed continuing support for the Illinois Council on Continuing Medical Education, reaffirming ISMS position on ICCME funding as defined by the House at the 1978 annual meeting. Mandated strict budgetary review and suggested an increase in fees for ICCME services prior to consideration of deficit spending. (78N-37, 52, 53)

REFERENCE COMMITTEE "D"

1. Referred to the Board of Trustees for study a proposal to gather and disseminate information on actual costs of government health insurance programs now in effect, including the proportion subsidized by physicians in giving medical care to indigent persons. (78N-2)
2. Deleted from the policy manual obsolete statements: (A) asking the Illinois State Medical Inter-Insurance Exchange to main-

tain in its bylaws a guarantee of due process, (B) requiring that upper level ISMS representatives and local physicians be included in planning and development of Illinois health programs financed by government funding, and (C) encouraging ISMS participation in Community Health Week. (78N-3, 4, 14)

3. Encouraged initiation of legislation to designate "Code Blue Care"—defined as institutionally designated, life threatening emergencies requiring CPR—as a "Good Samaritan" act. (78N-38)
4. Adopted a set of guidelines for physician professional advertising. The guidelines—which shall apply to solo-practitioners and groups of physicians—are suggested for medical groups, clinics, hospitals and medical institutions. They are not intended for utilization in any legislative activity. They are intended to allow physician advertising which is in compliance with the AMA Principles of Medical Ethics and current rules of law, and which does not promote or produce unfair competition. (78N-39)
5. Referred to the Board of Trustees for study certain suggestions in the advertising guidelines referred to above. Those items referred relate to advertising of fees, changes in professional identification, accepted forms of remuneration and overt solicitation. (78N-39)
6. Authorized ISMS to initiate legislative action to assure that hospital admission, (including initial and subsequent involuntary certification) treatment and discharge procedures related to mental and physical illness remain in all cases the exclusive responsibility of a physician licensed to practice medicine in all its branches. (78N-50)
7. Encouraged physicians to seek family approval for postmortem examination in all deaths, emphasizing the educational benefits of autopsy. (78N-51)
8. Authorized the Society to seek legislative reform of the legal system to implement Article 1, Section 12 of the Illinois Constitution which would facilitate countersuits against frivolous malpractice litigation. (78N-54)
9. Encouraged legislation providing legal defense, indemnification and, when appropriate, immunity for physicians serving state and local government agencies as vol-

unteers, independent contractors or employees. (78N-55)

10. Opposed a proposed OSHA rule concerning access to individual, identifiable employee medical records as contrary to law and medical confidentiality, and incompatible with the best interests of the patient and public policy. Directed the Society to: (A) provide testimony by a physician knowledgeable in occupational medicine at upcoming OSHA hearings; and (B) ask the AMA to follow suit. (78N-58).

OLD BUSINESS

At its 1978 Annual Meeting, the House of Delegates referred resolutions which pertained to recommendations of the National Commission on the Cost of Medical Care to the Board of Trustees for study. The 1978 AMA Annual Meeting House of Delegates acted on 30 Commission recommendations. The ISMS Board of Trustees responded to each of those actions. This Interim Session House ratified ISMS Board response in each instance.

Report A of the ISMS Board of Trustees requested House action on matters which had been referred to the AMA Board for study and will be debated at the December AMA Interim Meeting House of Delegates. The ISMS Board had sent recommendations for AMA Board study, and now asked the Interim Session House to review those actions. The House approved or amended those recommendations in resolution form, acting as follows:

1. Endorsed the concepts of neutral public policy and fair market competition among all health care delivery systems and asked the AMA Board to seek objective assessment of HMOs, including IPAs and other group arrangements, with respect to impact on health care access, quality and cost. (78A-51)
2. Asked the AMA to: (A) urge the Health Insurance Association of America and Blue Cross/Blue Shield to refrain from providing policies which penalize patients for selecting their physicians' offices for performance of medical and surgical procedures; and (B) support adjustment of governmental and private insurance benefit packages to provide balanced coverage of alternative settings and services. (78A-55)
3. Endorsed the concept of voluntary planning, mandating that planning legislation

should continue to be monitored in terms of cost, benefits, effectiveness and administrative activities to fulfill federal requirements. Opposed public utility-type regulation of the medical profession. Found the certificate of need to be a non-proven concept requiring continued evaluation. (78A-60)

4. Endorsed implementation of voluntary programs to achieve "decertification" or conversion of facilities found to exceed community needs on an experimental basis. (78A-62)
5. Reaffirmed support for appropriate preventive care and early detection screening services, specifying that the necessity of these services should be evaluated on the bases of appropriateness and cost. (78A-43)
6. Advocated establishment of regulatory systems to certify and monitor the performance of third party payers for fiscal responsibility and accurate representation of premium or capitation costs and benefits which would not inhibit third party efforts to develop innovative approaches to coverage. (78A-31)

In response to Board Report B, the House of Delegates took the following action on another resolution referred to the Board for study at the 1978 Annual Meeting:

1. Rejected as unfeasible a proposal to launch a massive public information campaign aimed at repealing P.L. 93-641, the National Health Planning and Resource Development Act. (78A-12)

In response to Board Reports C and D, the House of Delegates took the following actions on resolutions referred to the Board for study at the 1977 Interim Meeting:

1. Rejected a resolution requesting a feasibility study at selected hospitals considering seven-day versus five-day institutions on the basis of investigation by the Task Force on Cost Effectiveness. (77N-52)
2. Stipulated that ISMS will continue to investigate adequacy of health care availability and needs. (77N-50)

SPECIAL ACTIONS

1. Endorsed a memorial resolution extending sympathy to the family of Joseph L. Bordenave, M.D. Dr. Bordenave, of Geneva, was a former chairman of both the ISMS Board of Trustees and the ISMIS Board of

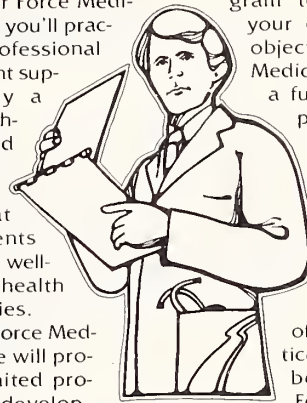
Trustees. The resolution cited his years of service as a practicing physician and a leader of organized medicine.

2. Extended sympathy to the family of David C. Christy, M.D., a Watseka physician and former president of the Iroquois County Medical Society. The resolution commended years of leadership both in his profession and his community.
3. Voted to name Jacob E. Reisch, M.D., former ISMS secretary-treasurer, Honorary ISMS President. Dr. Reisch, Springfield, is a former delegate to the AMA, as well as former ISMS trustee and delegate to the House. The resolution read in part: "No physician has served this Society more faithfully or is more deserving of the highest honor it can bestow."
4. Robert R. Hartman, M.D., presented a plaque to Eugene Balthazar, M.D., citing six years of "unparalleled public service by a member of the medical profession." Dr. Balthazar was lauded for establishing a free medical clinic, which he maintained at personal expense from 1972-78, to serve indigent citizens of Aurora.

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Actions on Resolutions

November, 1978 Interim Meeting

House of Delegates

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
Reference Committee on Constitution & Bylaws			
78N-15	James Laidlaw for Board of Trustees	Amendment to Chapter IX, Section 2, of the Bylaws Revising Areas of Concern of Council on Economics & Peer Review	Referred to B of T
78N-16	James Laidlaw for Board of Trustees	Amendment to Chapter IX of the Bylaws Describing the Committee on Third Party Payment Processes	Adopted
78N-17	James Laidlaw for Board of Trustees	Amendment to Chapter IX of the Bylaws to Describe the Areas of Concern of the Council on Medical Services	Adopted
78N-18	James Laidlaw for Board of Trustees	Amendment to Chapter IX of the Bylaws Expanding the Charge to the Council on Affiliate Societies	Adopted as editorially corrected
78N-19	P. John Seward for Board of Trustees	Streamlining Operation of the Interim Session of the House of Delegates	Referred to B of T
78N-24	Robert Tucker	Transferring Tazewell County Medical Society to the 4th Trustee District	Adopted
78N-25	James Laidlaw for Board of Trustees	Revision of Chapter XI of the Bylaws	Adopted as amended & editorially corrected
78N-26	James Laidlaw for Board of Trustees	Amendment to Chapter IV—House of Delegates By Adding a New Section 12 to be Titled: <i>Judicial Panel</i>	Adopted
78N-27	James Laidlaw for Board of Trustees	Repeal of Section 2C—Judicial Duties of Chapter VII—The Board of Trustees	Adopted
78N-28	James Laidlaw for Board of Trustees	Deletion of Section 6D of Chapter IX—Committees	Adopted
78N-29	James Laidlaw for Board of Trustees	Chapter X—County Societies— Revision Section 5	Adopted
78N-30	James Laidlaw for Board of Trustees	Amendment to the Constitution	Adopted

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
78N-47	George T. Wilkins Clifton L. Reeder	Duties of the President	Referred to B of T
78N-48	A. Everett Joslyn	Revisions in Peer Review	Adopted
78N-49	A. Everett Joslyn	Definition of Peer Review	Adopted as editorially corrected

Reference Committee "A"

78N-5	Lawrence L. Hirsch for Board of Trustees	Revision of Policy on Committee Appointments	Adopted
78N-6	Lawrence L. Hirsch for Board of Trustees	Deletion of Administrative Polices— Education, Primary & Secondary; Facility Medical Boards (Physicians) and Federal Funds—from Policy Manual	Adopted
78N-7	Lawrence L. Hirsch for Board of Trustees	Revision in Policy Statement on Specialty Society Representation on ISMS Councils	Withdrawn
78N-8	Lawrence L. Hirsch for Board of Trustees	Deletion of Relative Value Statement from Policy Manual	Adopted
78N-11	Lawrence L. Hirsch for Board of Trustees	Deletion of Statement on Fee Schedules from Policy Manual	Referred to B of T
78N-12	Lawrence L. Hirsch for Board of Trustees	Deletion of Ethics Statement from Policy Manual	Adopted
78N-20	Samuel J. Schimel	Lowering Malpractice Insurance Rates as Cost Containment Measure	Rejected
78N-23	James DeBord	Resident Delegate from Illinois to AMA House of Delegates	Rejected
78N-31	James P. Campbell	Liability Coverage for Medical Society Officers	Adopted
78N-35	J. R. O'Donnell	Reporting on the Implementation of Resolutions	Rejected
78N-40	Morris T. Friedell for Board of Trustees	Utilization Review of All Patients	Adopted as amended
78N-42	Robert R. Hartman for Board of Trustees	Second Opinion for Surgery	Referred to B of T
78N-43	Ernest Adams	Distribution of Information Regarding Dues & Assessments	Referred to B of T
78N-44	George T. Wilkins	AMA Delegation Operation Under Unit Rule Concept	Withdrawn
78N-45	George T. Wilkins	Membership List by Legislative Districts	Withdrawn
78N-56	Walter Stevenson	Second Opinions Before Surgery Requested by Insurance Companies	Not considered

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
78N-59	Lawrence L. Hirsch	The Establishment of Ethical Standards	Adopted
78N-61	David S. Fox	Second Opinion for Surgery	Not considered
78A-50 Old Business	<i>Board of Trustees</i>	Economic Incentives in Purchasing Insurance and Health Plans	Ratified B of T Action in Lieu of 78A-50
Substitute 78A-51 Old Business	<i>Board of Trustees</i>	Fair Market Health Plan Competition	Substitute for Substitute 78A-51 adopted
78A-52 Old Business	<i>Board of Trustees</i>	Alternative Financing Arrangements	Ratified B of T Action in Lieu of 78A-52
78A-53 Old Business	<i>Board of Trustees</i>	Information on Alternate Health Care Plan Benefits	Ratified B of T Action in Lieu of 78A-53
78A-54 Old Business	<i>Board of Trustees</i>	Reimbursement Levels for Providers	Ratified B of T Action in Lieu of 78A-54
Substitute 78A-55 Old Business	<i>Board of Trustees</i>	Utilization in Appropriate Settings	Substitute for Substitute 78A-55 adopted
77N-52 Old Business	Robert L. Cavens	Health Care Institutions Functioning 7 Days	Rejected

Reference Committee "B"

78N-9	Lawrence L. Hirsch for Board of Trustees	Revision of Public Aid Statement in Policy Manual	Adopted
78N-13	Lawrence L. Hirsch for Board of Trustees	Revision of Policy Statement on Comprehensive Health Planning	Adopted
78N-34	Kenneth Hurst	Illinois Department of Public Aid Invasion of Privacy	Adopted as amended
78N-36	Ronald M. Severino	Health Planning at State Level	Substitute adopted as amended
78N-60	David S. Fox	National Health Insurance	Substitute adopted as amended
Substitute 78A-58 Old Business	<i>Board of Trustees</i>	Reimbursement Restrictions	Ratified B of T Action in Lieu of 78A-58
Substitute 78A-59 Old Business	<i>Board of Trustees</i>	Incentives to Limit Bed Capacity	Ratified B of T Action in Lieu of 78A-59
Substitute 78A-60 Old Business	<i>Board of Trustees</i>	Planning	Substitute for Substitute 78A-60 adopted as editorially amended
78A-61 Old Business	<i>Board of Trustees</i>	Certificate of Need	Ratified B of T Action in Lieu of 78A-61

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
78A-62 Old Business	<i>Board of Trustees</i>	Decertification	Substitute adopted as amended
78A-63 Old Business	<i>Board of Trustees</i>	Regional Centers	Ratified B of T Action in Lieu of 78A-63
78A-64 Old Business	<i>Board of Trustees</i>	Capital Expenditure Limits	Ratified B of T Action in Lieu of 78A-64
78A-68 Old Business	<i>Board of Trustees</i>	Placement Review Criteria	Ratified B of T Action in Lieu of 78A-68
78A-12 Old Business	Melvin Freedman	Substitute Proposal for P.L. 93-641 National Health Planning & Resource Development for 1974	Rejected

Reference Committee "C"

78N-1	M. B. Kirschenbaum	Medical School Admissions and Physician Shortage Areas	Referred to B of T
78N-10	Lawrence L. Hirsch for Board of Trustees	Deletion of Statement on Nurses Shortage from Policy Manual	Rejected
78N-21	Robert R. Hartman for Board of Trustees	IMJ Publication of Clinical Materials from ISMS-Sponsored Meetings	Substitute adopted as editorially corrected
78N-22	H. Frank Holman	How Then Shall We Define Life?	Rejected
78N-32	Thomas W. Stach	Joint Commission on Accreditation of Hospitals	Substitute adopted
78N-33	Morgan M. Meyer	Cost Containment	Adopted 78N-57 in Lieu of 78N-33
78N-37	C. A. DeKovessey	Evaluation of Continuing Medical Education	Substitute 78N-53 Adopted in Lieu of 78N-37, 52 & 53
78N-41	John W. Ovitz	Illinois State Medical Society Policy on Cost Containment	Rejected
78N-46	George T. Wilkins	Physicians' Negotiating Agency	Referred to B of T
78N-52	Gregory G. Spano	Value of ICCME to Illinois Physicians	Substitute 78N-53 Adopted in Lieu of 78N-37, 52 & 53
78N-53	Gregory G. Spano	Evaluation of Continuing Medical Education	Substitute adopted
78N-57	Clifton L. Reeder	Cost Containment	Adopted
78A-40 Old Business	<i>Board of Trustees</i>	Assessment & Assurance of Quality of Care	Ratified B of T Action in Lieu of 78A-40
Substitute 78A-41 Old Business	<i>Board of Trustees</i>	Criteria & Use of Practice Evaluation Techniques	Ratified B of T Action in Lieu of 78A-41
Substitute 78A-42 Old Business	<i>Board of Trustees</i>	Inappropriate Medical Care	Ratified B of T Action in Lieu of 78A-42

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
Substitute 78A-43 Old Business	<i>Board of Trustees</i>	Preventive Services	Substitute for Substitute 78A-43 adopted as amended
78A-44 Old Business	<i>Board of Trustees</i>	Multiphasic Health Evaluations	Ratified B of T Action in Lieu of 78A-44
78A-45 Old Business	<i>Board of Trustees</i>	Health & Patient Education	Ratified B of T Action in Lieu of 78A-45
78A-46 Old Business	<i>Board of Trustees</i>	Incentives to Provide Appropriate Care	Ratified B of T Action in Lieu of 78A-46
78A-47 Old Business	<i>Board of Trustees</i>	Diagnostic Findings	Ratified B of T Action in Lieu of 78A-47
78A-48 Old Business	<i>Board of Trustees</i>	Technology Assessment & Information Dissemination	Ratified B of T Action in Lieu of 78A-48
78A-49 Old Business	<i>Board of Trustees</i>	Research Toward Cost- Savings Innovations	Ratified B of T Action in Lieu of 78A-49
78A-71 Old Business	<i>Board of Trustees</i>	Supply Guidelines	Ratified B of T Action in Lieu of 78A-71
78A-72 Old Business	<i>Board of Trustees</i>	Physician Supply	Ratified B of T Action in Lieu of 78A-72
78A-73 Old Business	<i>Board of Trustees</i>	Professional Attractiveness	Ratified B of T Action in Lieu of 78A-73
78A-74 Old Business	<i>Board of Trustees</i>	Loan Forgiveness and Scholarships	Ratified B of T Action in Lieu of 78A-74
78A-75 Old Business	<i>Board of Trustees</i>	Recruitment from Underserved Areas	Ratified B of T Action in Lieu of 78A-75
78A-76 Old Business	<i>Board of Trustees</i>	Family Practice	Ratified B of T Action in Lieu of 78A-76
78A-77 Old Business	<i>Board of Trustees</i>	Curricula on Economics of Health Care	Ratified B of T Action in Lieu of 78A-77
78A-78 Old Business	<i>Board of Trustees</i>	Limit Restrictions on Defusion of New Technologies	Ratified B of T Action in Lieu of 78A-78
77N-50 Old Business	Robert L. Cavens	Shortage of Health Care Personnel & Facilities	Substitute adopted

Reference Committee "D"

78N-2	M. B. Kirschenbaum	Government Influence on Cost of Medical Care	Referred to B of T
78N-3	Lawrence L. Hirsch for Board of Trustees	Revision in Policy Statement on Professional Liability	Adopted
78N-4	Lawrence L. Hirsch for Board of Trustees	Deletion of Policy Statement on Medical Representation in Gov't. Planning	Adopted as amended

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
78N-14	Lawrence L. Hirsch for Board of Trustees	Deletion of Community Health Week Statement from Policy Manual	Adopted
78N-38	Morgan M. Meyer	Code Blue Care	Adopted
78N-39	George T. Wilkins for Board of Trustees	Physician Professional Advertising Guidelines	Adopted as amended (Section II, No. 11 & 12, Section III, No. 8 & 10, referred to B of T)
78N-50	J. R. O'Donnell	Hospital Admission, Care & Dis- charge Responsibility of Physicians	Adopted
78N-51	C. B. Lara	Declining Number of Autopsies	Adopted as amended
78N-54	Wayne N. Leimbach	Illinois State Medical Society to Seek Legislative Redress for the Injured Innocent	Adopted as amended
78N-55	Robert T. Fox for Board of Trustees	Indemnification of Physicians Employed by State or Local Governments	Adopted
78N-58	Audley F. Connor, Jr.	Opposition to Proposed Rule Giving OSHA Employees Access to Patient Records	Adopted as amended
Substitute 78A-31 Old Business	<i>Board of Trustees</i>	Regulation of Insurance Carriers & Health Plans	Substitute for Substitute 78A-31 adopted as amended
Substitute 78A-32 Old Business	<i>Board of Trustees</i>	Prospective Rate Setting for Hospitals	Ratified B of T Action in Lieu of 78A-32
78A-33 Old Business	<i>Board of Trustees</i>	Evaluating Public Utility Regulation & Exemptions From It	Ratified B of T Action in Lieu of 78A-33
78A-34 Old Business	<i>Board of Trustees</i>	Review of Regulatory Process	Ratified B of T Action in Lieu of 78A-34
78A-35 Old Business	<i>Board of Trustees</i>	Modify Restrictions on Allied Health Personnel	Ratified B of T Action in Lieu of 78A-35
78A-69 Old Business	<i>Board of Trustees</i>	Defensive Medicine	Ratified B of T Action in Lieu of 78A-69

The following resolutions were considered by the House of Delegates without referral to a Reference Committee:

Robert R. Hartman	Memorial Resolution— Joseph L. Bordenave, M.D.	Adopted
Kenneth A. Hurst	Memorial Resolution— David C. Christy, M.D.	Adopted
Robert R. Hartman for Board of Trustees	Honorary ISMS President— Jacob E. Reisch, M.D.	Adopted

Board Abstracts

(Continued from page 392)

- *Counterclaims/Malicious Prosecution*: Expand the definition of malicious prosecution to enable physicians to sue without the requirement of special damages and to permit the filing of such counterclaims in the original cause of action, without having to wait for a favorable verdict.
- *Section 41*: Require courts to hold hearings on motions filed under Section 41 of the Illinois Civil Practice Act. Currently, the court may refuse to hear the motion which, if granted, would force plaintiffs to pay defense costs in frivolous suits.

The Society also will seek legislation to: (1) Permit physicians to treat minors for alcohol intoxication without parental consent; (2) Define attacks on emergency room personnel as a Class 3 felony (aggravated battery); and (3) Exempt from the legal "discovery" process records of the Illinois State Medical Inter-Insurance Exchange peer review committee.

ISMS will oppose any legislation requiring annual license renewal based on testing of clinical competence and CME accomplishment. House Proposal 148—mandating the requirement—is pending in the General Assembly and could be introduced as legislation during the next session.

Physician Recruitment

ISMS will survey county medical societies, hospital administrators and health service agencies in an effort to identify medically underserved areas of Illinois. Survey results will enable the ISMS Committee on Physician Recruitment to assess area manpower "needs" from three perspectives, rather than relying solely upon physician-patient ratios. The Society was directed last year by the House of Delegates to identify areas having an acute shortage of health care personnel and facilities, and to study inequities among those areas.

In a related action, the Board placed the Physician Recruitment Program and Doctor's Job Fair under the purview of the Council on Education and Manpower—parent body of the Committee on Physician Recruitment. The Job Fair and Recruitment Program previously were operated as administrative activities.

New Health Practitioners Committee

ISMS will appoint a Committee on New Health Practitioners to monitor activities involving all classes of so-called "physician extenders." The Committee will function under the Council on Education and Manpower.

Cost Containment

As a result of the House of Delegates' approval of Resolution 78N-40—which urged hospital medical staffs to perform focused UR of all patients—the Task Force on Cost Effectiveness will develop a pilot project utilizing appropriate alternatives to inpatient hospital care, with comparable coverage by third party payers. ISMS also will: (1) Encourage institutions and their medical staffs participating in focused review to explore alternatives to in-hospital care and report their findings to the Task Force; and (2) Lend whatever resources are available to support these demonstration projects.

ISMS also will explore the development of an ongoing education program on cost effectiveness—with a detailed curriculum of training resources—for presentation to hospital medical staffs. In preparing the program, ISMS will seek the cooperation of the Illinois Hospital Association, Chicago Hospital Council, Blue Cross/Blue Shield and participating hospitals.

The Illinois State Cost Containment Committee—a joint ISMS-Illinois Hospital Association group charged with implementing the Voluntary Effort to control health costs—will be urged to implement, if feasible, a pilot project modeled after a program in Utah based upon the "swing-bed" concept. Under the program, under-utilized acute care beds are used for long-term care patients. Society representatives to the ISCCC will suggest that the ISCCC consider encouraging medical staffs to: (1) Establish cost benefit committees with broad departmental participation; and (2) Inform the ISCCC of its implementation by January 1.

Generic Consent Form

The Illinois Department of Public Health will be urged to incorporate an ISMS-developed patient consent form into regulations governing the generic substitution law. The form would be signed by a patient to authorize the pharmacist to substitute a generic drug. It is designed to help monitor the substitution program, prevent inappropriate substitution and afford some liability protection to physicians. If IDPH does not mandate use of the form via regulation, ISMS will seek legislation requiring its use.

Co-Sponsor Seminars

ISMS will co-sponsor the following seminars:

- *Mental Health Code* (co-sponsors Illinois Department of Mental Health and Developmental Disabilities and Illinois Hospital Association): Designed to acquaint physicians and hospital administrators with ramifications of the new Code. Two meetings—one in Chicago and the other in Springfield—are slated for November and December.
- *Fetal Alcoholism Syndrome* (co-sponsors Illinois Nurses Association and March of Dimes): Scheduled for June 18, 1979. Program and specific location to be announced in near future.
- *Physicians' Workshop on Epilepsy* (co-sponsor University of Illinois' Comprehensive Program for Children with Epilepsy): Scheduled for May '79 in Chicago. Possible topics include: Seizures in children; seizures associated with operative lesions; legal implications of epilepsy; and relationship between epilepsy and learning disabilities.
- *Medical-Legal Seminar* (co-sponsor American Society of Law & Medicine); Scheduled for April 19, at Peoria Hilton Hotel. Topic will be legal pitfalls in medical practice.

The Board approved sponsorship of a practice management seminar during the 1979 ISMS annual meeting, provided its producer—V. Mueller Company—agrees to guidelines formulated by the Board. The all-day session—titled "Establishing Yourself in a Private Practice"—also was presented at the 1978 annual meeting.

Special Committee Formed

A special ad hoc committee—composed of past ISMS presidents and Board chairmen—was formed to study the duties of the ISMS president, Board chairman and executive administrator . . . and the operating interrelationships of ISMS, IFMC, ICCME, ISMIS and ISMIE. The committee—which will function without staff assistance and report to the Board next March—will be co-chaired by Dr. George Wilkins, immediate past president, and Dr. Robert Fox, immediate past Board chairman. Other members are: Drs. Joseph Skom, Jerry Ingalls, Fredric Lake, William Lees and Willard Scrivner.

Reimbursement Denial

ISMS will study the feasibility of creating a patient advocate committee to assist in resolving reimbursement denials by private carriers and government. In studying the retrospective denial issue, ISMS will ask the Illinois Hospital Association to survey its member institutions to determine the extent of hospital reimbursement denial.

AMA Chiropractic Suit

The Illinois Delegation to AMA was instructed to work for conciliation of the split between the American College of Radiology and AMA over the Association's acceptance of settlement terms in the highly-publicized chiropractic suit in Pennsylvania. The Illinois Delegation was instructed to deal with the problem "according to established policies of ISMS, backed up by their best judgment based on background, experience and serious consideration, in an effort to conciliate this dangerous division in the house of medicine."

CME/ICCME

The Board voted to support ICCME's proposed 1979 programs—which includes employing a professional educator—that will be funded by the \$10 AMA-ERF allocation plus that amount necessary to accomplish goals coming from general funds. The ISMS Finance Committee will consider the ICCME budget annually in terms of accomplishing its stated goals . . . and base its recommendations on the total funds available for allocation rather than a per capita amount.

In other action concerning ICCME, the Board:

- Directed that management of ICCME should be by its executive director who is responsible to the ICCME Board, which, in turn, is responsible to the ISMS Board.
- Directed the Planning and Priorities Committee to consider the possibility of reducing the size of the ICCME Board and change the composition so that it is primarily made up of ISMS Board members. All members would be approved by the ISMS Board.
- Approved the suggestion of the Planning and Priorities Committee to control ICCME finances via deficit financing . . . and approve ICCME's aims and goals with subsequent approval of the budget.

ISMS will not seek accreditation to grant Category I credit for CME programs. Instead, ICCME—which already has the accreditation—will be asked to co-sponsor CME programs meeting requirements for Category I. Last June, the Board voted to seek accreditation in the interest of programming freedom, which now can be obtained by ICCME co-sponsorship.

The Board approved an increase in CME accreditation fees effective January 1, but will continue to waive the registration fee for county medical societies. Meanwhile, the Board will urge the national Liaison Committee on CME to institute several revisions in its proposed changes in the types and duration of accreditation.

Second Opinion Programs

ISMS will voice objection to the Health Insurance Association of America over policies which provide a lesser benefit if the patient undergoes elective surgery: (1) Without seeking a second opinion; or (2) Despite a second opinion which does not confirm the need for the procedure. The programs also utilize the "closed panel" arrangement which forces patients to obtain the second opinion from those physicians listed on a roster formulated by the program's sponsor. ISMS also will register an objection with the Prudential Insurance Company which is marketing such a plan in Illinois.

IDVR Advisory Committee

ISMS has recommended to the Illinois Division of Vocational Rehabilitation that its soon-to-be-formed Medical Advisory Committee should: (1) Review counselors' performances and evaluators' reports; and (2) Establish liaison with specialty groups, particularly the Illinois Physician Medical and Rehabilitation Society and the Illinois Academy of Family Practice. In addition, the Society recommended that IDVR's relationships with facilities should require that the institution is accredited by the Commission on Accreditation of Rehabilita-

tion Facilities. ISMS emphasized that the relationships should take into account a patient's geographic and personal needs and not be limited to institutions favored by counselors.

Student Business Section

County medical societies will be encouraged to organize and provide assistance to local components of the Student Business Session (SBS) and Resident Physicians Section (RPS). The Board noted that while SBS and RPS assure student and resident input into ISMS activities, it does not activate them on the local level. Component societies which have medical schools within their counties will be asked to appoint a representative to a special ISMS committee charged with coordinating the activities of these local groups. The Illinois Delegation to AMA will urge the Association to encourage state and county societies throughout the country to assist state and local SBS and RPS components.

IDPA Drug Manual

The following drugs were approved for inclusion in the IDPA Drug Manual: Parlodol, Florone Ointment, Florone Cream, Quibron Plus Elixir, Quibron Plus Capsules, Simecone Suspension, and Westcort (Hydrocortisone Valerate) Cream 0.2% (under dermatologic preparations).

Appointments/Nominations

The Board approved the following appointments:

- *Dr. Warren Tuttle*, Harrisburg—Committee on Accreditation
- *Dr. Donald Ferguson*, Chicago—Committee on Physician Recruitment
- *Dr. Joseph O'Donnell*, Glen Ellyn—consultant, Committee on Health Planning
- *Dr. Robert Johnson*, Springfield—consultant, Student Business Session
- *Dr. Jere Freidheim*, Chicago—consultant, Resident Physicians Section
- *Drs. Leroy Levitt*, Chicago; and *Donald Sellers*, Park Ridge—Panel for the Impaired Physician
- *Dr. Michael Van Dyce Hinken*, Rockford—Scientific Speakers Bureau of the Alcoholism Education Program
- *Cyril L. Friend, D.D.S.*, Metropolis—State Technical Advisory Committee to ISMS Jail Health Project (upon recommendation of Illinois State Dental Society)

ISMS Past President Dr. Jerry Ingalls, Paris, was named to assume January chairmanship of the Illinois State Cost Containment Committee—a joint ISMS-Illinois Hospital Association group charged with implementing the Voluntary Effort in Illinois. The chairmanship alternates annually between Medical Society and Hospital Association appointees. Dr. Ingalls currently serves as ISCCC vice-chairman.

Dr. Henrietta Herbolsheimer, Chicago, was nominated for reappointment to the State Health Coordinating Council.

Nominated for appointment to the Illinois Health Facilities Planning Board's Committee to Study Regulation of Hospices were: Drs. Obert Lay, Granite City; Steven Cullinan and Irving Weigenberg, Peoria; Andre Lascari, Michael Stokes and Charles Wabner, Springfield; and Shirely Roy, Bertram Moss, Kermit Mehlinger and Edwin Miller, all of Chicago.

Nominated for appointment to the IDVR Medical Advisory Committee were: Drs. Aaron Rosenthal, Park Ridge; Hugh McMenamin, Peoria; Stephen Jarrett, Rock Island; Eric Ericson and Robert Lund of Rockford; and Kate Kohn, Henry Betts and Sidney Alpert of Chicago. Because rehabilitative service requires a team approach involving therapists and others in related fields, ISMS also nominated the following non-physicians: Herbert Schultz, C.P., and Barbara Nandzik, P.T., of Rockford; and William Gellman, Ph.D., Chicago.



ISMS Interim Meeting

RPS Chairman – Delegate's Report

BY LINDA L. HUGHEY, M.D./WILMETTE

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

To The Resident Members of ISMS:

The Interim Meeting of the ISMS House of Delegates was held in Rockton, Illinois on November 4th and 5th.

The meeting was attended by 3 resident representatives: B. Barry LeCompte, M.D., (Resident Housestaff Association, Rush-Presbyterian St. Luke's Hospital); James DeBord, M.D. (Chief Surgical Resident, University of Illinois Hospitals) and Ira J. Isaacson, M.D. (Senior Anesthesia Resident, Northwestern University). Dr. DeBord and Dr. Isaacson served as alternate delegate and delegate to the Interim Meeting for the residents.

The main issue for the residents at this time was a resolution submitted by the RPS which asked for a resident member (delegate and alternate) appointment to the Illinois Delegation to the AMA House of Delegates. This resolution had been defeated without discussion at the Annual Meeting in 1978.

At this Interim Meeting the resolution was discussed in detail by both proponents and opponents to the resolution. Some of the issues raised by the opponents included: (1) the lack of experience of residents in such political matters; (2) the length of service of such a delegate is often many years and by definition a resident would be a "short-term" member and (3) that residents should go through the regular county society channels for election to the Illinois Delegation to the AMA.

As proponents we argued: (1) the issues of

statistical representation (there are 14 Illinois AMA delegates and not 13 because there are over 1,000 resident members of ISMS); (2) that residents in lengthy training programs could easily serve 2-4 year terms in the delegation; (3) that the residents are a separate special section as defined by the By-laws of this Society.

An additional point not raised but very pertinent to future discussion is that at the state level the resident section is a separate group. We are neither a part of the upstate nor downstate caucuses, which recommend AMA delegates and therefore we need not go through the regular channels at the county level.

The Reference Committee, after much deliberation agreed "that an effective AMA delegation depends upon the experience of physicians who can continue service for a long period of time. Nonetheless, the committee agrees that input from resident members is valuable, and that their continued participation should be encouraged." The Reference Committee recommended that our resolution be amended to provide for an *alternate* delegate position for a resident to the Illinois Delegation to AMA House of Delegates. The residents in attendance at the meeting felt that at this time, this recommendation was a reasonable compromise.

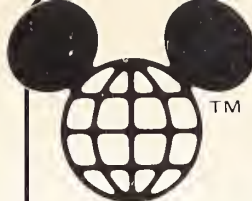
However, on the floor of the House of Delegates this proposed amended resolution was again discussed in detail. The opponents raised arguments similar to above. The discussion

seemed evenly divided between proponents and opponents. Unfortunatley, on a standing vote this amended resolution was *defeated* by the House of Delegates 91 for and 101 against. As this total (192) was greater than the number of voting delegates originally listed at the start of the session, a recount was requested and this request was defeated.*

This was a hotly contested issue and one which should be brought to the House of Delegates at each session until we are successful in this reasonable endeavor. We have (as the vote reflects) a significant amount of regular member support. I firmly believe we can succeed at the Annual Meeting in May, 1979.

Ira J. Isaacson, M.D.
Chairman, ISMS-RPS
ISMS Delegate

**Editor's Note: The number of delegates present at the time a vote is requested, rather than the number present for the opening tally, constitute voting strength. Delegates are not disenfranchised by tardiness.*



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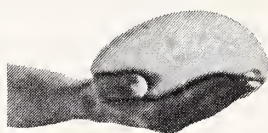
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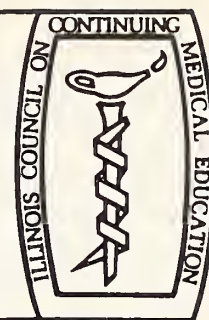
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JANUARY

Family Medicine

ETHICAL ISSUES IN CRITICAL CARE

For: GP's. Lecture, Jan. 10, 2:00-5:00 p.m., Chicago. Sponsor: The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago 60637. Fee: \$20. Reg. limit: none. CME Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Elaine Ehrman. Phone: 312-947-5777.

Family Medicine

UPDATE—PRIMARY CARE MEDICINE

For: GP's, FP's, Internists. Lectures, Jan. 5 & 26, 8:00 a.m., Chicago. Sponsor: Grant Hospital, 550 W. Webster, Chicago 60614. Fee: none. Reg. limit: none. CME Credit: AMA Category 1, 2 hours. Contact: P. Colon. Phone: 312-883-2112.

Family Medicine

9TH ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS

For: FP's. 3-day course, Jan. 17-19, Pfister Hotel, Milwaukee, Wisc. Sponsor: Department of Family Practice, The Medical College of Wisconsin, 610 North 19th St., Milwaukee, Wisc. 53233. Cosponsor: SE Chapter, Wisconsin Academy of Family Physicians. Reg. deadline: 1/5. Fee: \$160. Reg. limit: 225. Credit: AAFP Prescribed, 21 hours; AMA Category 1, 21 hours. Contact: Susanna Rechlitz. Phone: 414-933-0700.

Family Therapy

PERSONAL/PROFESSIONAL GROWTH WORKSHOP FOR THERAPISTS: WITH OR WITHOUT PARTNERS

For: MD's, therapists. Seminar, Jan. 25, 26, 27, Oak Park. Speaker: Charles Kramer, MD. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Reg. limit: 16. CME Credit: AMA Category 1, 17 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

Family Therapy

LAW IN THE EVERYDAY PRACTICE OF PSYCHOTHERAPY

For: MD's. Workshop, Jan. 26 & 27, 9:30-4:30 p.m., Chicago. Speaker: Sandra Nye, JD, MSW. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Reg. limit: 40. CME Credit: AMA Category 1, 12 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

OBGYN Pathology

UNDERSTANDING OVARIAN CYSTOMAS—HISTOGENESIS & CLINICAL IMPLICATIONS

For: Gynecologists, Pathologists. Lecture, Jan. 5, Chicago. Speaker: Ralph Richard, MD. Sponsor: Medical Education Dept., St. Joseph Hospital, 2900 No. Lake Shore Dr., Chicago, IL 60657. Cosponsor: Clyde J. Geiger, MD, Lectureship Endowment Foundation. Reg. deadline: 12/20. Fee: none. Reg. limit: none. Credit: AMA Category 1, 1 hour. Contact: Sharon Afafe. Phone: 312-975-3002.

Internal Medicine

YEAR IN INTERNAL MEDICINE

For: GP's. 3-day conference, Jan. 24-26, Chicago. Sponsor: Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago, IL 60611. Credit: AMA Category 1, 21 hours. Contact: James Dyson, PhD. Phone: 312-649-8533.

Internal Medicine

RHEUMATIC DISEASES: CURRENT CONCEPTS OF PATHOGENESIS, DIAGNOSIS AND MANAGEMENT

For: Rheumatologists, Internists, FP's. Lecture, Jan. 18, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, Ann Arbor, Michigan 48109. Fee: \$130. Reg. limit: 400. Credit: AAFP Prescribed, 18 hours; AMA Category 1, 18 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Medicine

14th ANNUAL MEETING

For: FP's. Symposium/workshop, Jan. 14-19, Las Vegas, Nevada. Speaker: Michael De Bakey, MD. Fee: \$250. Reg. limit: none. CME Credit: AMA Category 1, 40 hours. Sponsor: American Society of Contemporary Medicine and Surgery, 6 No. Michigan Ave., Chicago 60602. Contact: John Bellows, MD. Phone: 312-236-4673.

Medicine/Surgery

RENAL TRANSPLANTS—COST AND QUALITY OF LIFE VS. DIALYSIS

For: MD's. Lecture, Jan. 17, 1:00 p.m., Good Samaritan Hospital, 3815 Highland Ave., Downers Grove, IL 60515. Speaker: Jesse Hano, MD. Sponsor: DuPage County Medical Society, 26 W. St. Charles Rd., Lombard, IL 60148. Reg. limit: none. Fee: none. Credit: AAFP Elective, 3 hours; AMA Category 1, 3 hours. Contact: Lillian Widmer. Phone: 312-495-4050.

Medicine/Surgery

24th MEDICAL/SURGICAL SEMINAR FOR LAKE COUNTY

For: MD's. Seminar, Jan. 24, 8:00 a.m.-1:15 p.m., Waukegan. Sponsor: St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. Fee: \$250. Reg. limit: none. Reg. deadline: Jan. 19. Credit: AAFP Elective, 5 hours; AMA Category 1, 5 hours. Contact: R. M. Adelman, MD. Phone: 312-688-5800.

Ophthalmology

14th ANNUAL SCIENTIFIC ASSEMBLY

For: Ophthalmologists. Seminars/lectures/workshops, Jan. 14-19, Las Vegas, Nevada. Sponsor: American Society of Contemporary Ophthalmology, 6 No. Michigan Ave., Chicago 60602. Fee: \$250. Reg. limit: none. CME Credit: AMA Category 1, 40 hours. Contact: John Bellows, MD. Phone: 312-236-4673.

Ophthalmology

THE ROLE OF THE PRIMARY PHYSICIAN IN EYE CARE

For: FP's, Internists, Pediatricians. Workshop, 3 sessions in 1979, Chicago. Sponsor: Dept. of Ophthalmology, University of Illinois, 1855 W. Taylor, Chicago 60612. Fee: \$200/session. Reg. limit: 40. CME Credit: AMA Category 1. Contact: Carmen Carrasco. Phone: 312-996-8023.

Pediatrics

MIDWEST CONFERENCE ON TRANSCUTANEOUS PO₂ MONITORING IN THE NEWBORN INFANT

For: Pediatricians, Anesthesiologists, Resp. Therapists. 2-day conference, Jan. 18-19, Water Tower Hyatt House, Chicago. Sponsor: University of Illinois College of Medicine, Dept. of Pediatrics, Office of Continuing Education Services, 1853 W. Polk St., Room 144, Chicago, IL 60612. Fee: \$125; \$75, residents, interns, students. Reg. limit: 250. Credit: AMA Category 1, 13 hours. Contact: Sue Korienek. Phone: 312-996-8025.

Psychiatry/Psychology

NARCISSISTIC FACTORS IN PSYCHOTHERAPY

For: MD's, Psychiatrists. Lecture, Jan. 17, 1:00-4:00 p.m., Forest Park. Speaker: Arnold Goldberg, MD. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. Fee: \$15. CME Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312-771-7000.

FEBRUARY

Anesthesiology

REGIONAL ANESTHESIA

For: Anesthesiologists. 5-day lecture, Feb. 26, Chicago. Speaker: Vincent Collins, MD. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL 60612. Fee: \$325. Reg. limit: 10. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Ear, Nose and Throat

COMMON EAR, NOSE AND THROAT PROBLEMS

For: GP's. Lecture, Feb. 14, 1:30-4:45 p.m., Chicago. Sponsor: The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637. Fee: \$20. Reg. limit: none. Credit: AAFP Elective, 3 hours; AMA Category 1, 3 hours. Contact: Mrs. Elaine Ehrman. Phone: 312-947-5777.

Emergency Care

EMERGENCY MEDICINE

For: FP's, Emergency MD's. Lecture/workshop, Feb. 19-23, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, Ann Arbor, Michigan 48109. Cosponsor: American College of Emergency Physicians, Michigan Affiliate. Fee: \$275. Reg. limit: 500. Credit: AAFP Prescribed, 35 hours; AMA Category 1, 35 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Family Medicine

UPDATE—PRIMARY CARE MEDICINE

For: GP's, FP's, Internists. Lectures, Feb. 2, 16, 23, 8:00 a.m., Chicago. Sponsor: Grant Hospital, 550 W. Webster, Chicago, IL 60614. Fee: none. Reg. limit: none. Credit: AMA Category 1, 3 hours. Contact: Ms. P. Colon. Phone: 312-883-2112.

Family Medicine

CLINICAL MEDICINE UPDATE

For: GP's, FP's. 5-day lecture, Feb. 19, Chicago. Speaker: Sheldon Waldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL 60612. Fee: \$225. Reg. limit: 100. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Family Therapy

THE THERAPIST'S OWN FAMILY

For: Therapists. Lecture series, Feb.-June, 9:00-1:00 p.m., Oak Park. Speaker: Jeannette Kramer. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. Cosponsor: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$150. Reg. limit: none. Credit: AMA Category 1, 20 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

Family Therapy

FAMILY SYSTEMS ASSESSMENT—INTRODUCTORY COURSE

For: Therapists. Course, Feb. 5-9, Chicago. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. Cosponsor: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$155. Credit: AMA Category 1, 27.5 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

Family Therapy

INTEGRATION OF CULTURAL HISTORY INTO ASSESSMENT AND INTERVENTION

For: Therapists. 3-day conference, Feb. 22-24, Chicago. Speakers: George Vassiliou, MD., Vasso Vassiliou, PhD. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago, IL 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$120. Credit: AMA Category 1, 18 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

Family Therapy

STRATEGIES AND TECHNIQUES—INTERMEDIATE COURSE

For: Therapists. Course, Feb. 12-16, Chicago. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. Cosponsor: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Credit: AMA Category 1, 27.5 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

Forensic Medicine

REVIEW OF CURRENT FORENSIC PATHOLOGY CASES

For: MD's, DDS's, LIB's. Lecture/workshop, Thursdays, 2:00 p.m., Chicago. Sponsor: Office of the Medical Examiner, Cook County, IL, 1828 West Polk St., Chicago, IL 60612. Fee: none. Reg. limit: 50. Contact: Robert Stein, MD. Phone: 312-443-5017.

Internal Medicine

USE OF THE LABORATORY IN CLINICAL PRACTICE

For: Internists, FP's, GP's. Symposium, Feb. 22-23, St. Louis, Missouri. Sponsor: Office of CME, Washington University School of Medicine, Box 8063, 660 So. Euclid, St. Louis, Missouri 63110. Fee: \$120. Reg. limit: 150. Credit: AAFP Elective, 12 hours; AMA Category 1, 12 hours. Contact: Loretta Giacoletto. Phone: 314-454-3873.

Internal Medicine

TB TODAY

For: Internists, FP's, GP's. Symposium, Feb. 15-16, St. Louis, Missouri. Sponsor: Office of CME, Washington University School of Medicine, Box 8063, 660 So. Euclid, St. Louis, Missouri 63110. Fee: \$120. Reg. limit: 150. Credit: AAFP Elective, 12 hours; AMA Category 1, 12 hours. Contact: Loretta Giacoletto. Phone: 314-454-3873.

Medicine

5th ANNUAL INTERNAL MEDICINE SYMPOSIUM

For: MD's, office staff. Symposium, Feb. 9-10, Springfield. Sponsor: SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. Credit: AMA Category 1, 10 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Neurology

NEUROLOGY, PART I, BASIC

For: Neurologists, Psychiatrists. 5½-day Lecture, Feb. 26, Chicago. Speaker: Neil Allen, MD. Sponsor: Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. Fee: \$250. Reg. limit: 150. Credit: AMA Category 1, 44 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Pediatrics

DETECTION, MANAGEMENT OF CHILD ABUSE

For: MD's, office staff. Symposium, Feb. 14, 9:00 a.m.-12:00 noon, Centerville. Sponsor: SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Psychiatry

TOPICS IN PSYCHOSOMATIC AND BEHAVIORAL MEDICINE

For: Psychiatrists, primary care physicians. Lecture, Feb. 27-28, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME Ann Arbor, Michigan 48109. Fee: \$120. Reg. limit: 350. Credit: AAFP Prescribed, 14 hours; AMA Category 1, 14 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Psychiatry

SYSTEMS AND STRATEGIES IN FAMILY THERAPY

For: Psychiatrists. Lecture, Feb. 21, 1:00-4:00 p.m., Forest Park. Speaker: Peggy Papp, ACSW. Sponsor: Riveridge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. Fee: \$15. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312-771-7000.

Surgery

SPECIALTY REVIEW COURSE IN THORACIC SURGERY

For: General and Cardiothoracic Surgeons. 6-day lecture, Feb. 13, Chicago. Speaker: Sidney Levitsky, MD. Sponsor: Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. Fee: \$250. Reg. limit: 200. Credit: AMA Category 1, 48 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Surgery

SPECIAL REVIEW COURSE IN NEUROLOGICAL SURGERY

For: Neurosurgeons, Neurologists. 10-day lecture, Feb. 2, Chicago. Speaker: Leonard Krantzler, MD. Sponsor: Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. Fee: \$425. Reg. limit: 250. Credit: AMA Category 1, 104 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

MARCH

Family Therapy

SIXTH ANNUAL SPRING CONFERENCE: TREATMENT OF MARITAL COUPLES

For: Psychiatrists, Therapists. 2-day conference, March 30-31, Continental Plaza Hotel, Chicago. Speaker: Clifford Sager, MD. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago, IL 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Credit: AMA Category 1, 12 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

Gastroenterology

NEW DEVELOPMENTS IN INFLAMMATORY BOWEL DISEASE

For: GP's. Lecture, March 14, 1:30-5:00 p.m., Chicago. Sponsor: The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637. Fee: \$20. Reg. limit: none. Credit: AAFP Elective, 3 hours; AMA Category 1, 3 hours. Contact: Elaine Ehrman. Phone: 312-947-5777.

Hematology

HEMATOLOGY REVIEW

For: Hematologists, Medical Technicians. Lecture/Lab., March 6-9, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for Continuing Medical Education, Ann Arbor, Michigan 48109. Fee: \$225, MD; \$175, Techs. Reg. limit: 325. Credit: AMA Category 1, 28 hours; AAFP Elective, 28 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Internal Medicine

INTERNAL MEDICINE BOARD EXAMINATION REVIEW

For: MD's. Weekly lectures, March-May, Monday evenings, St. Louis, Missouri. Sponsor: Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 So. Euclid, St. Louis, Missouri 63110. Fee: \$120. Reg. limit: 175. Credit: AAFP Elective, 36 hours; AMA Category 1, 36 hours. Contact: Loretta Giacoletto. Phone: 314-454-3873.

Internal Medicine

A DAY OF CLINICAL GASTROENTEROLOGY

For: FP's, Internists. Lecture, March 24, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for Continuing Medical Education, Ann Arbor, Michigan 48109. Fee: \$70. Reg. limit: 350. Credit: AMA Category 1, 7 hours; AAFP Elective, 7 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Internal Medicine

AN UPDATE IN RENAL DISEASES

For: MD's. Symposium, March 1-2, St. Louis, Missouri. Sponsor: Washington University School of Medicine, Continuing Medical Education, Box 8063, 660 So. Euclid, St. Louis, Missouri 63110. Fee: \$120. Reg. limit: 150. Credit: AAFP Elective, 12 hours; AMA Category 1, 12 hours. Contact: Loretta Giacoletto. Phone: 314-454-3873.

Occupational Health

WELLNESS IN THE WORK PLACE—

PREVENTIVE MEDICINE

For: MD's, nurses. Seminar, March 9-10, Water Tower Hyatt House, Chicago. Sponsor: Central States Occupational Medical Association, 119 Shabbona Dr., Park Forest, IL 60466. Cosponsor: American Occupational Medical Association. Fee: \$30. Reg. limit: none. Credit: AAFP Elective, 9 hours; AMA Category 1, 9 hours. Contact: Rita Packer. Phone: 312-747-8124.

Pediatric Urology

PEDIATRIC UROLOGY

For: Urologists, Pediatricians. Seminar, March 9-10, Chicago. Sponsor: American Urological Association, P.O. Box 1129, Aspen, Colorado 81611. Fee: \$200, AUA; \$250, non-AUA. Reg. limit: 300. Credit: AMA Category 1, 16 hours. Contact: Jean Greiner. Phone: 303-925-2018.

Pediatrics

ADVANCES IN PEDIATRICS

For: Pediatricians. Lecture, March 14-16, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for Continuing Medical Education, Ann Arbor, Michigan 48109. Fee: \$180. Reg. limit: 350. Credit: AAFP Prescribed, 21 hours; AMA Category 1, 21 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Surgery

GENERAL SURGERY CONFERENCE

For: Surgeons. Lecture, March 22-23, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for Continuing Medical Education, Ann Arbor, Michigan 48109. Fee: \$140. Reg. limit: 250. Credit: AAFP Elective, 14 hours; AMA Category 1, 14 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

INCREASE IN CME ACCREDITATION FEES

Due to rising administrative costs, the ISMS Board of Trustees has approved a new fee structure for Illinois CME sponsors seeking accreditation status. The following fees are effective as of January 1, 1979:

Registration fee	\$100
(waived for ISMS component societies)	
Accreditation survey fee for medical organizations with 49 or fewer members	\$300
All other CME sponsors	\$450

MEDICINE FOR TODAY

Winter Sessions

For: Family Practitioners (emphasis on Cardiology, Gynecology, Endocrinology, Pulmonary). 30th Annual Postgraduate Program of the Illinois Academy of Family Physicians. CME Credit: AMA Category 1, 30 hours; AAFP Prescribed, 30 hours. Fee: \$100, members; \$110, non-members. Schedule includes:

- Belleville—Feb. 22; Mar. 1, 8, 15, 22, 29
- Berwyn—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4
- Beverly—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4
- Centralia—Feb. 21; Mar. 7, 21
- Champaign—Mar. 1, 15, 29
- Chicago Nearwest—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4
- Chicago North—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4
- Chicago Southwest—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4
- Harvey—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4
- Hinsdale—Feb. 21; Mar. 7, 21
- Melrose Park—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4
- Park Ridge—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4
- Peoria—Feb. 22; Mar. 8, 22
- Rockford—Mar. 1, 15, 29
- Rock Island—Feb. 22; Mar. 8, 22
- Springfield—Mar. 1, 29

For complete information, contact: Illinois Academy of Family Physicians, 1200 Harger Road, Suite 405, Oak Brook, Illinois 60521. Phone: 312-325-8502.

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pain

Freedom
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fear



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Cardilate® (erythrityl tetranitrate)

INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustments of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

DOSAGE: Therapy may be initiated with 10 mg sublingually prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/ sublingual scored tablets also supplied in bottle of 1,000.

Also available: Cardilate®-P (Erythrityl Tetranitrate with Phenobarbital)* Tablets (Scored).

(*Warning—may be habit-forming.)

1. Taken sublingually, Cardilate® (erythrityl tetranitrate) begins to work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to two hours.

2. Fear of pain, a major deterrent to achieving acceptable (and desirable) levels of activity, including sex, may be allayed with Cardilate. Effective prophylaxis and improved exercise tolerance help toward normalizing the lives of anginal patients.

Cardilate®

(erythrityl tetranitrate)

A close-up photograph of a monarch caterpillar with its characteristic black, white, and orange stripes, crawling on a green milkweed stem. The plant has several clusters of small, white, daisy-like flowers. The background is a soft-focus green.

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A unique clinical option...
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Optimine[®] 1 mg. tablets

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Long-acting antihistamine relief

B.I.D. dosage provides sustained symptomatic relief for up to 24 hours. Helps to keep patients adequately controlled

Prolonged duration of antihistamine action is inherent in the molecular structure...not due to tablet coatings or other slow release processes

B.I.D. effectiveness

Patients can fit OPTIMINE into morning and evening routines...no need to carry medication. The easy-to-titrate, scored 1 mg. tablet permits dosage flexibility to meet individual patient requirements

No dyes

Contains no sensitizing dyes with their potential for causing allergic reactions

Optimine A practical antihistamine
to help allergy patients stay on therapy

CONTRAINDICATIONS Use in Newborn or Premature infants. This drug should not be used in newborn or premature infants.

Use in Nursing Mothers. Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease. Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma; stenosing peptic ulcer; pyloroduodenal obstruction; symptomatic prostatic hypertrophy, bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma; increased intraocular pressure; hyperthyroidism; cardiovascular disease; hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined.

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils; flushing, and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and 1/2 isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977

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For more complete details, consult package insert or Schering literature available from your Schering Representative of Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ARCOLA: Wanted-American trained F.P. to join established F.P. in active practice. Must do some O.B. Guaranteed salary and benefits. Eventual partnership. Robert N. Arrol, M.D., 126 S. Locust, Arcola, 61910. (217) 268-4444, or 268-4404. (12)

ATKINSON: Due to recent death of town's physician, a modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles from Peoria. All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235. (309) 936-7566. (12)

AURORA: Opening in General Internal Medicine with 40 man group. Complete office facilities. Good starting salary. Contact: L. E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506. (312-859-6700) (1)

CARBONDALE: G.P., F.P., or Internist for health service at prominent university which includes a school of medicine. Scenic recreational area combining the virtues of small town living with the cultural and shopping assets of a large metropolitan area. Attractive salary, 40 hour work week and generous fringe benefits. IL license required. A.A./E.O.E. For further information send vitae to Don Knapp, M.D., Medical Director, SIU-C Health Service, Carbondale, IL 62901. (3)

CHICAGO: Major Chicago based retailer seeking corporate physician. Up-to-date, modern facilities, regular hours and comprehensive employee benefits make this a very desirable position. Please send resume with salary requirements. Contact: Professional Employment Director, Sears, Roebuck & Co., D/707-2, Chicago 60684 (1)

FAIRFIELD: Population 6,500. Opening for OB-Gyn board eligible or certified and general practitioner to join group of two physicians (F.P. and surgeon). Complete office facilities, excellent salary and fringe benefits, opportunity to become full partner. Near university, junior college locally. Good fishing, hunting, cultural opportunities, all churches. Contact: S. W. Konarski, M.D., 401 East Center Street, Fairfield 62837. (618) 842-2187. (3)

HARVARD: An internist, OB-GYN for Northern Illinois commuter suburb. New hospital, good schools, guaranteed salary and benefits based on qualifications. Close to resort areas. A solid community economically. Contact: Dr. John P. Hill, 502 N. Hart, Harvard 60033. (815-943-5151) (1)

LA GRANGE: Western suburb of Chicago, medium sized hospital. Opening for Director of medical affairs, new position, full time. Work with medical staff on

CME, medical staff affairs, Family Practice Residency Program and University affiliation. Contact, Administrator, 312-352-1200. (2)

LISLE: Physician needed to assist me in handling my very extensive private family practice. Salary open, good opportunity for this relationship to merge into a partnership association. CONTACT: M. Sinkovits, 4513 Lincoln Ave., Lisle 60532. (312) 968-2735. (12)

MACOMB: GP-FP 12 month contract practice—University Health Service. Outpatient clinic—no OB, Surgery. Fringes include hospitalization, paid vacation, retirement, etc. Approximately 13,000 students, city 23,000. Competitive negotiable income. Equal opportunity affirmative action employer. Contact: C. E. Hughes, M.D., Director BEU Health Center, WIU, Macomb 61455. (1)

MATTOON: American trained family practitioner or internist for rewarding practice. Fully equipped office available—new 210 bed hospital (open staff)—financial startup assistance—University of Illinois, Urbana Medical Campus, 40 miles. Mattoon is a prosperous, growing community of 25,000 with a patient population of 75,000. Contact: A. Rauwolf, M.D., 1120 Wabash, Mattoon 61938. (217) 234-6253. (4)

PAXTON: Paxton Community Hospital is enlarging its medical staff due to expansion of the facility and has openings for Family Practitioners to locate in the community. A 30 bed, general short term acute hospital offers full services to the community except for OB. The hospital, in East Central Illinois, is approximately two hours from Chicago, St. Louis, and Indianapolis, and 30 minutes from University of Illinois. The hospital is fully accredited by the JCAH. Contact Mr. David Polge, Administrator, Paxton Community Hospital, 651 East Pells, Paxton 60957. Phone 217-379-2387. (12)

PEORIA: Economical sound central Illinois community of 250,000 situated in picturesque river valley has need for family physicians and general internists to practice in a 300 bed community hospital affiliated with the University of Illinois, College of Medicine. Office space and financial assistance available. "A GOOD PLACE TO PRACTICE GOOD MEDICINE." Contact: John A. Smith, Administrator, Proctor Community Hospital, 5409 N. Knoxville, Peoria 61614. (309-691-4702) (3)

WEST FRANKFORT: Population 10,000, county 42,000. Coal mining growth area (1,200 new jobs). Offices available near hospital. On I57/24 in Southern Illinois. Major university near. Good highways, and recreation. Need OB-GYN, IM-CV, IM-GP and FP. Financial assistance. Contact: Wm. D. Palmer, Administrator, UMWA Union Hospital, 507 W. St. Louis St., West Frankfort 62896. (618-932-2155) (1)



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Makes Sense in Hypertension*

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

*** Warning**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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IMPAC

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

Dear Colleague

Now that the rhetoric has stopped and the election votes tabulated, I thought you might be interested in how your medical political action committee fared at the polls.

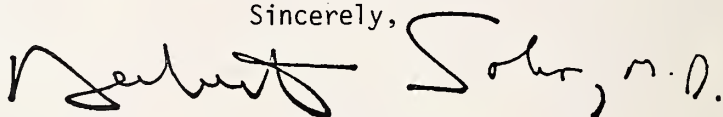
Overall, IMPAC's 1978 election results were impressive -- we participated in 238 contests and 218 IMPAC supported candidates were successful in their efforts to be elected to office, for a winning percentage of 91.5%. In the Illinois General Assembly, IMPAC supported 211 candidates, of which 197 were successful (93.3%) IMPAC supported 19 congressional candidates, 16 of whom won for a success ratio of 84.2%. And in the statewide races, IMPAC supported 8 candidates, 5 of whom were successful for a 62.5% winning percentage.

I find those statistics encouraging. They mean that in 238 separate cases, Illinois physicians were involved in political activity enough to ask your state medical political action committee for its support. Not all were successful -- but at least you made the effort.

At the same time, I find these statistics discouraging. IMPAC lost 20 contests, and I can't help wondering if a little more effort might have made the difference in some of those "too close to call" races. There were some surprises in this election -- some candidates which we supported even though we didn't think they could win were successful. Others which were considered "safe" lost. The end result -- a Republican governor, lieutenant governor, and U.S. Senator, a 13-11 Republican edge in the Illinois Delegation to the U.S. Congress, but a Democratic controlled Illinois State Senate and Illinois House of Representatives.

You will soon be receiving your 1979 dues billing and IMPAC membership solicitation. Please remember these important statistics and add your contribution to IMPAC when you write out the check for 1979 dues.

Sincerely,



Herbert Sohn, M.D.
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

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Doctor's News

DISASTER DRILL A SUCCESS—A simulated explosion in north Chicago's Horner Park provided the background for this year's successful rehearsal in disaster preparedness recently. The Chicago Northside Commission on Health Planning, Chicago Hospital Council, sixteen participant hospitals, medical, fire and police personnel successfully treated 135 "victims" in less than 45 minutes for "wounds" ranging from lacerations to multiple contusions.

EXCHANGE TO PAY DIVIDEND—The Illinois State Medical Inter-Insurance Exchange Board of Governors has declared a dividend to be paid to those current policyholders insured during the 1976-77 and 1977-78 policy years. The dividend, which will be paid after January 1, 1979, amounts to 5½% of premium paid during 1976-77 and 1% of premium paid during 1977-78. The total payment will amount to \$2.1 million.

FEBRUARY MEXICO TRAVEL PROGRAM—Reservations are still available for the ISMS-sponsored IXTAPA (Mexico) Holiday travel program, February 14-21. Departures for the eight day Mexican Riviera tour may be scheduled from Chicago and St. Louis. Price: \$629 per person, double. For further information, please contact ISMS headquarters (312-782-1654).

INCREASE IN CME ACCREDITATION FEES—In response to the relentless pressure of rising costs and inflation, CME accreditation fees have been increased—the first such raise since the initial fees were set in 1973. The following fees, adopted by the ICCME Board of Directors, and ISMS Board of Trustees, are effective as of January 1, 1979. Registration fee: \$100 (Waived for ISMS component societies); accreditation survey fee for medical organizations of 49 or fewer members: \$300; all other CME sponsors: \$450.

HEALTH CARE ACHIEVEMENT AWARDS—The Chicago-based Blue Cross and Blue Shield Plan recently announced the recipients of awards for private health sector progress in cost containment, quality and accessibility. Those honored were: Illinois Masonic Medical Center, Chicago; St. Francis Xavier Cabrini Hospital, Chicago; Perry Memorial Hospital, Princeton; George T. Mitchell, M.D., Marshall and Eugene P. Johnson, M.D., Casey; the Abraham Lincoln Health Maintenance Organization, Lincoln; Occupational Health Services, Rockford; United States Steel Corp. South Works; the River Bend Ambulance Association; and the Illinois Health Improvement Association. The awards were presented at a symposium, "Private Initiatives in Health Care," sponsored by Blue Cross/Blue Shield, and winners were selected by a committee comprised of representatives from the Chicago Hospital Council, Illinois Hospital Association, Chicago Medical Society, Illinois Clinic Managers Association, and ISMS. Watch the *Journal* for further details on innovations and projects which brought these awards.

MENTAL HEALTH AND THE LAW—An intradisciplinary organization to facilitate communication among lawyers, social workers, psychologists, psychiatrists, nurses and other professionals concerned with the interface of mental health and law has invited ISMS members to join or participate in their effort. The Illinois Academy of Mental Health and Law plans to sponsor programs and other activities in that area. Interested persons may contact Ronald Shlensky, M.D., Suite 1028, 251 E. Chicago Avenue, Chicago 60611.

NEONATAL DEATH—Findings reported recently to the Statewide Health Coordinating Council Ad Hoc Committee on Infant Mortality have indicated that the city of Chicago has the second-highest neonatal death rate among the five largest cities in the U.S. In discussing the problem, SHCC Chairperson Julia Cihak noted that 70% of all infant deaths in Illinois occur before infants reach one month of age. The Ad Hoc Committee has made the following recommendations: strengthened regional perinatal care programs through expanded follow-up care after discharge from intensive perinatal centers; greater professional and public education; extended prenatal care to high risk groups, and a vigorous attack on the causes of infant mortality. Persons interested in contributing to the Ad Hoc Committee's research are invited to write Charles Bennett, Statewide Health Coordinating Council, 525 W. Jefferson, Springfield 62761.

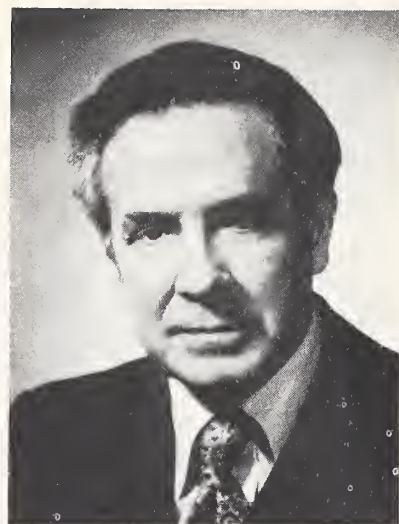
NEW JOURNAL ANNOUNCED—The Loyola University Medical Center recently initiated a quarterly publication, *Spina Bifida Therapy, An International Journal*. The Journal will deal solely with treatment and care of spina bifida from an interdisciplinary viewpoint. Those interested in subscribing should contact the Spinal Bifida Service at Loyola, 2160 S. First Avenue, Maywood, 60153.

SICKLE CELL PROGRESS—Research by a geneticist at the UI Medical Center in Chicago has brought a clue to a method for controlling sickle cell anemia. Joseph De Simone, Ph.D., recently reported that research in animals has indicated a possible link between the level of fetal hemoglobin and the sickling process. Preliminary research has found that persons with a hereditary tendency to maintain high levels of fetal hemoglobin—which normally accounts for less than one percent of human blood after the first year of life—may carry sickle cell disease but show no symptoms. Research is directed at methods to increase and maintain the level of fetal hemoglobin in the blood of susceptible persons.

PHYSICIANS IN THE NEWS—David A. Hilding, M.D., Winnetka, a professor of otorhinolaryngology at the UI Abraham Lincoln School of Medicine in Chicago, has been appointed medical director of the National Hearing Association. . . . James A. Campbell, M.D., president and chief executive officer of Rush-Presbyterian-St. Luke's Medical Center, has been elected president of Alpha Omega Alpha, the national medical honor society. . . . The University of Health Sciences/Chicago Medical School has elected Joseph M. White, M.D., to serve as president. Doctor White, chairman-elect of the national coordinating council on medical education, is currently provost for health affairs at the University of Missouri-Columbia.

Harold N. Walgren, Hinsdale, has been elected president of the Civil Aviation Medical Association. . . . Saint Mary of Nazareth Hospital has elected new officers for 1979. They are Doctors Donald C. Wharton, president, Walter J. Kawula, Lake Forest, president-elect, Nelson D. Sanchez, Western Springs, secretary, Bruno Valadka, Elmwood Park, treasurer and Orest Jachtowycz, Chicago, general staff representative.

The American College of Chest physicians conferred the status of Fellowship to ten Illinois physicians at their recent meeting. Those honored were: Antonio Q. Chan, Oak Brook, Anwar S. Choudhry, Westmont, Rosemary M. DeLeon, Lombard, Iraj Delfani, Wilmette, Lanie E. Eagleton, Springfield, David L. Fishman, Evanston, Vishnu D. Gaiha, Evanston, Hae C. Lee, Palos Heights, Ralph E. Otto, Evanston and Ivan L. Shapiro, Carol Stream. . . . Abbott Laboratories recently presented Jacob L. Marks, M.D., Homewood, with an engraved "Golden Hour Clock" to commemorate 50 years of outstanding service and dedication to medicine.



SPEAK UP

Criticizing the medical profession and the health care system appears close to attaining the status of a "national pastime." The most devoted participants in this new game are those advocating national health insurance.

Senator Kennedy's hearings throughout the country on NHI have captured the news media's attention. Front page accounts of the system's deficiencies are reinforced by nightly TV newscasts. Focal points of the media coverage are the hand-picked witnesses Senator Kennedy presents at each session to detail financial ruin caused by health costs.

Considering the potential impact of this media coverage, it is easy to conclude that the public must, by now, have become hostile toward the profession and the health system. If that assessment is correct, there really is nothing we can do to regain public support and ward off government medicine.

Fortunately, my experience indicates that the public generally is satisfied with the health care system and is not anxiously awaiting the arrival of NHI. During my travels throughout the state, I have addressed civic groups and appeared on audience-participation radio programs. It was comforting to learn that the majority of people view our health care system as the finest in the world . . . and believe that its faults can be remedied without dismantling the entire system.

How long will that attitude prevail? Considering the widespread attention given to the negative aspects of health care, one can only conclude that the public's opinion gradually will change. That is inevitable unless we take the offensive.

Physicians are in an ideal position to mold public opinion. That faceless mass referred to as the "general public" is composed of our patients.

It's about time we speak up!

A handwritten signature in dark ink that reads "David S. Fox". The signature is stylized with a large, sweeping 'D' and a cursive 'Fox'.

David S. Fox, M.D., President



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Viewbox

(Continued from page 391)

CORRECT DIAGNOSIS:

4. SARCOIDOSIS

The original chest radiographs suggest a fine milliary pattern of the lungs.

The gallium scan demonstrates prominent increased uptake in the pulmonary parenchyma as well as multiple areas of increased uptake over both hila.

The combination of these findings is suggestive of sarcoidosis of the lung.

Other entities that could produce a similar appearance in the correct clinical setting are:

1. Recent lymphangiography. However, it is not expected that lymphangiography would produce positive hilar nodes on gallium scan. The administration of ethiodol can produce an inflammatory reaction in the lung that will be positive on gallium scan.

2. Interstitial pneumonitis. Interstitial pneumonitis could produce patchy areas of increased uptake in the lung, but would likely not produce areas of this uniformity of uptake nor would the hilar nodes be as prominently identified.

3. Pneumoconioses have been reported to concentrate gallium as well.

4. Idiopathic pulmonary fibrosis can also have a positive gallium scan and gallium is useful in monitoring the progress of the disease.

5. Bleomycin toxicity will also produce diffuse gallium uptake in the lung. This is a reversible phenomenon and disappears after cessation of therapy.

6. Common inflammatory diseases including tuberculosis and pyogenic pneumonias will also show increased gallium uptake in a focal fashion.

The pattern of diffuse pulmonary uptake with prominent hilar uptake is most suggestive of sarcoidosis. Indeed, in this patient, there is biopsy evidence of sarcoidosis.

Normal accumulation of gallium in the lungs does not occur. The presence of intense lung uptake or focal lung uptake should be thoroughly evaluated. In patients with known lymphomas, a history should be obtained concerning recent lymphangiography. In the absence of recent lymphangiography, pleural or parenchymal involvement in the lung by the lymphomonous process should be considered.

References

1. Heshiki, A., Schatz, S. L., McKusick, K. A., *et al.*, "Gallium-67 Scanning In Patients With Pulmonary Sarcoidosis," *Am. J. Roentg., Rad. Ther. and Nuc. Med.*, 122:744, 1974.
2. Hoffer, P. B., Bekerman, C., Henkin, R. E.: *GALLIUM-67 IMAGING*, John Wiley & Sons, New York, 1978.

EKG

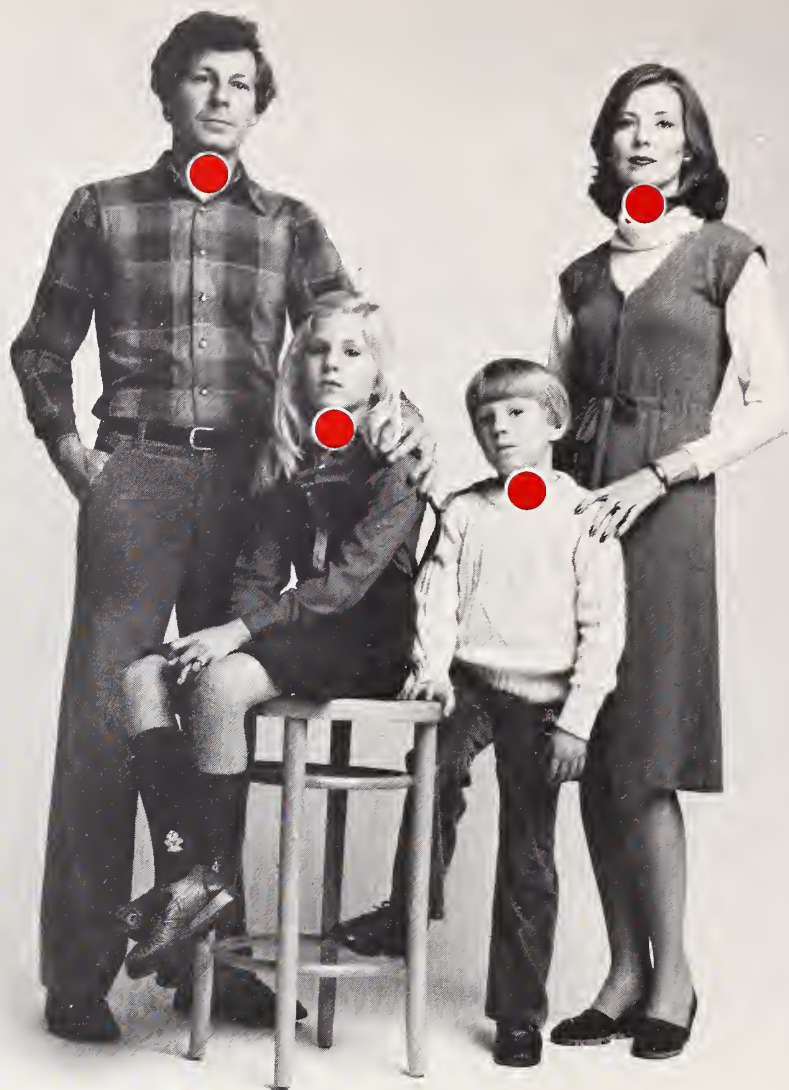
(Continued from page 399)

Answers: 1. E. 2. D.

The top line shows a normal ST segment response to exercise at a heart rate of 150 beats per minute. Beats 14 and 15 are a couplet or pair of premature ventricular beats. Beat 16 is a sinus beat followed by another premature ventricular beat and a subsequent run of ventricular flutter at a rate of more than 300 beats per minute. In the middle rhythm strip, the ventricular flutter is deteriorating to ventricular fibrillation when a 400 watt-second direct current counter-shock is applied to the patient. The bumps in the second half of the middle strip as well as the bottom strip are the result of cardiopulmonary resuscitation (CPR). In the middle of the bottom strip, sinus bradycardia at a rate of 46 beats per minute can be seen when CPR is momentarily stopped. Subsequently, one milligram of Atropine was given and the patient was

transferred to the Coronary Care Unit. No myocardial infarction was demonstrated by enzymes or ECG changes. The patient was discharged seven days later with a greater understanding of the importance of his medications.

This experience points to the fact that the bypass surgery does not eliminate foci of ventricular irritability although they may be more easily controlled with drugs post-operatively. It also confirms the low incidence of death on the treadmill despite the fact that patients with serious cardiac disease may be submaximally stressed. Malignant cardiac arrhythmias are promptly controlled because equipments, drugs, and staff trained in CPR are available in the exercise lab. Although large numbers of patients taking Procainamide must discontinue it because of toxicity, our patient simply reduced his dose gradually because he did not like taking medicine. For further reading in these areas, see B. D. Kosowsky, *et al.*, *Circulation* 47:1204, 1973 on Procainamide and I. F. Tabry, *et al.*, *Circulation* 58:I-166, 1978, Cardiovascular Surgery Supplement, on the effect of surgery on ventricular tachyarrhythmias.



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OPPORTUNITIES FOR PHYSICIANS IN INDIANA—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

EMERGENCY DEPARTMENT PHYSICIAN: Become part of an expanding, dynamic multispecialty clinic in midwest university community of 100,000. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801, (217) 337-3239.

FAMILY PRACTITIONER—To associate with one senior general practitioner and one surgeon in rural southern Illinois. Excellent educational system and recreation. Financially sound community. One hour from St. Louis. JCAH 72-bed hospital in Nashville. Association available now. Contact: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois, (618) 327-8236.

ILLINOIS—PEORIA—Interviewing career Emergency Physicians for full-time openings starting immediately and Jan. 1. Opportunity to join young ACEP oriented physicians' group in 550-bed Medical-Surgical Hospital affiliated with Peoria School of Medicine. Good specialty backup. Flexible scheduling. Superior compensation with liberal fringe benefits including malpractice. Contact H. T. Stratton, M.D.; Methodist Medical Center, 221 NE Monroe, Peoria, IL 61636; (309) 672-4974 or (309) 672-5501.

PHYSICIAN WANTED. Full or part time for fully equipped medical center. Large welfare practice. 2823 N. Clybourn, Chicago, Ill. 60618. Telephone—(312) 929-6999 or 664-3157.

OCCUPATIONAL MEDICINE—National corporation needs associate medical director in Skokie, Illinois; occupational medical experience desirable. Corporation dedicated to comprehensive health program for all employees; modern well equipped facilities; liberal fringe benefits include life and health insurance, excellent savings plan, malpractice insurance coverage, liberal vacation, holiday and sick leave policies, etc.; salary commensurate with position responsibilities, experience and professional training. Send resume in confidence to Box 935, c/o Illinois Medical Journal. An Equal Opportunity Employer.

PHYSICIAN WANTED: General medical services to be provided to psychiatric patients. Full and part-time positions available. Generous fringe benefits. Salary negotiable. 50 minutes from downtown Chicago. Contact Claude Roush, Superintendent, Manteno Mental Health Center, Manteno, Illinois 60950. (815) 468-3451.

LOCUM TENENS—EMERGENCY MEDICINE—available in our 100 hospitals; monthly scheduling is flexible and according to your preferences; malpractice is paid, excellent hourly income according to your flexibility and hours worked. Call toll free 1-800-325-3982, ext. 220 for details.

OPPORTUNITY IN FAMILY PRACTICE—Two Board Certified Family Physicians need third physician. New office connected to new hospital (250 beds) with all ancillary and specialized services available. Any interested physicians please send curriculum vitae to Link, Chapman & Associates, Inc., 1515 West Truman Road, Independence, Missouri 64050, or call collect 816-836-8200; 9:00 a.m. to 4:30 p.m.

IN PATIENT CLINIC PRACTICE at Illinois Developmental Centers; various locations. Monday through Friday, days only, no night or weekend call. Guaranteed income of \$40,000-\$50,000. Send CV to T. P. Cooper, M.D., 970 Executive Parkway, St. Louis, MO 63141, or call toll free 1-800-325-3982.

ORTHOPEDIC SURGEON who desires to locate in a rural area of southern Illinois needed to serve two community hospitals. One hour from St. Louis. Good educational system for children. Excellent recreation. Reply: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263.

A PROGRESSIVE RURAL COMMUNITY in midwestern Indiana desires to secure two or more general practitioners. Interested parties would find new schools, a new nursing home, new banks, good hospitals nearby, etc. A medical center with purchase option will be built to accommodate these physicians. Contact J. D. Piech, 1600 E. Liberty, Covington, Indiana. (317) 793-4818.

ILLINOIS DEVELOPMENTAL CENTERS: Background in primary care and psychiatry helpful; Interdisciplinary team approach. Monday-Friday, days only, nights or weekends optional; excellent remuneration; Illinois license required. Contact T. P. Cooper, M.D., 970 Executive Parkway, St. Louis, MO 63141 or call toll free 1-800-325-3982, ext. 213.

FAMILY PRACTICE SPECIALIST NEEDED in busy expanding, future oriented, multispecialty clinic to participate in development of new department; three department members plan curriculum for AAFP approved family practice residency; ample opportunity for developing, fulfilling, primary practice and personal development; located in university community; liberal financial and fringe benefits. Contact: Medical Director, Carle Clinic, Urbana, IL 61801. (217) 337-3239.

MATTOON-CHARLESTON, ILLINOIS—Sara Bush Lincoln Health Center Emergency Department has openings for qualified physician; guarantee \$50,000-\$55,000 with ideal working conditions and schedule. Send curriculum vitae to Stephen Allin, M.D., Emergency Department Director, P.O. Box 372, Mattoon, Illinois 61938 or call toll free 1-800-325-3982 for details.

EMERGENCY PHYSICIAN—WOOD RIVER, ILLINOIS, St. Louis area hospital treating 15,000 patients annually. Excellent nursing staff, modern facility. Flexible scheduling, 2/24 hour shifts a week. Remuneration from \$47,000. Paid malpractice insurance. Send curriculum vitae to Judy Patterson, M.D., Director of EMS, Wood River, IL 63136 or call toll free 1-800-325-3982.

PRACTICE AVAILABLE—Retirement dictates sale of most profitable obesity control practice located in Rockford, Illinois, approximately 4,000 patients with an unlimited growth potential. Contact: Mrs. Curt Steffen at (815) 965-5983.

OPENING FOR Board Certified Cardiologists, Internists, Pediatricians, Rheumatologist, OB/GYNs, Ophthalmologists, Emergency Room Physicians, Orthopedic Surgeons, and Family Practitioners in Dallas, Austin and numerous cities in Texas. Also need two Family Practitioners and Orthopedic Surgeon in Chicago. Must have Flex or Illinois license. Group and solo practices available. NO FEE. Send C.V. or call Wellington Smith, Texas Doctors Group, Box 177, Austin, Texas 78767. (512) 476-7129.

STAFF PHYSICIAN WANTED—The Johnston R. Bowman Health Center for the Elderly at Rush Presbyterian-St. Luke's Medical Center is seeking a Board Certified internist to serve as a full time staff physician caring for acute and rehabilitative patients at our unique health care facility. Salary negotiable with private practice opportunities available. Please contact Rhoda S. Pomerantz, M.D., Medical Director, at (312) 942-7021.

PHYSICIAN NEEDED for full and part time. Family practice in inner city. For further information, contact Judy Brown (312) 751-4000.

THREE YEAR APPROVED PSYCHIATRIC RESIDENCY Program now appointing for an immediate unexpected opening for July, 1979. Small intensive psychiatric hospital, JCAH approved, affiliated with Univ. of Iowa Medical College. Comprehensive program including two adult psychiatric units, adolescent unit, children's unit, alcohol & drug abuse unit, with innovative community liaison, and OPD. Eclectic approach. Situated in picturesque NE Iowa near large cities with cultural advantages, but in rural setting. Ideal for family living. No financial sacrifice while learning. Top salary: first year \$23,478, second year \$24,648, third year \$25,896; liberal fringe benefits; some housing available. Opportunity to join staff upon completion of training. All applicants must have completed one year in an American approved training program in internal medicine, family practice, or pediatrics or a flexible one year program, including four months in internal medicine. Write or call J. T. May, M.D., Superintendent, or B. J. Dave, M.D., Director of Education, Mental Health Institute, Independence, Iowa 50644.

FAMILY PRACTITIONER—NEEDED IMMEDIATELY to join present three doctor family practice group that is incorporated; practice is equally divided between office and hospital; location is northwest suburb of metropolitan Chicago; beginning salary is \$40,000 to \$45,000 the first year based on qualifications; full partnership available with an opportunity to invest in the clinical building; there will be equal sharing of night call and weekend call among the group from the beginning of the association; this is an excellent opportunity for a family practitioner who is Board certified or qualified. Contact Clinical Assoc., S.C. c/o Dr. George L. Lagorio, 484 Lee Street, Des Plaines, Ill. 60016. Telephone AC 312-827-3101.

FAMILY PRACTICE OPPORTUNITY—Central Washington State, need M.D. interested in general family practice with 4 day week. Have 3 P.A.'s on board for all night and weekend work. Considerable general practice, peds, OB and surgery; willing to provide additional training in surgery and obstetrics. Above average salary, negotiable. Housing available. Very well equipped hospital. Need additional help due to partner retiring. Mostly young family area, population 12,000, moderate growth expected. Call collect day or night: Richard P. Bunch, M.D., 361 E. Main, Othello, Wa. 99344. Office: (509) 488-3282, (509) 488-9252, Home: (509) 488-5044.

ACCREDITED FIVE-YEAR GENERAL SURGERY RESIDENCY program at Illinois Central Community Hospital, 5800 Stony Island Avenue, Chicago, Illinois, (312) 643-9200. Positions available in July, 1979, are PGY1 and PGY2 levels. Contact: Dr. William Lawrence, Chief of Surgery.

EMS CONCEPT now being developed in Orlando, Florida by Medical Emergency Service Associates (MESA), S.C. Now hiring only the most qualified physicians to staff emergency department. High pay, excellent working conditions, flexible scheduling and fringe benefits available to qualified physicians for work in Orlando emergency departments. Send all CVs to: M.E.S.A., 188 Industrial Drive, Suite 316, Elmhurst, Illinois 60126.

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MEDICAL OFFICE SUITE FOR RENT, Lincoln-Belmont Bldg. 715-1200 square feet, available at once in full service, elevator, active professional building. Call Gary Solomon, (312) 334-5400.

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FOR THE INDIVIDUAL OR GROUP desiring the ultimate piece of residential property in the western suburban area. Eleven plus acre estate in Naperville with nine hundred plus foot frontage on the Du Page River. Estate landscaped and covered with hundreds of beautiful, mature oak and blue spruce trees. Price \$680,000. Shown by appointment. 355-8998.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and

acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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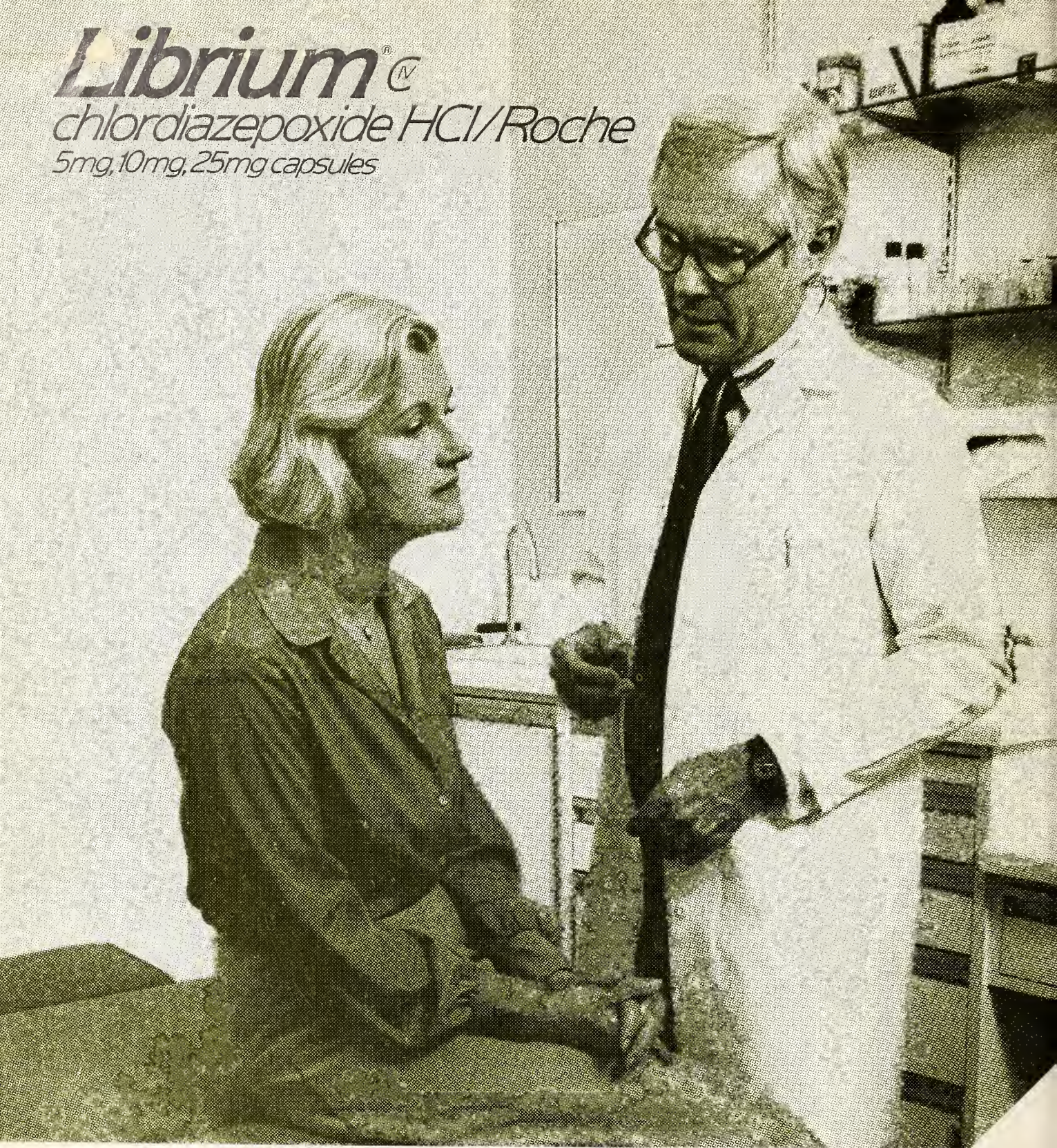
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